

# PREVENTION AND MANAGEMENT OF CHLAMYDIAL INFECTIONS IN **ADOLESCENTS:** A TOOLKIT FOR CLINICIANS

January 2004

SECOND EDITION











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# **Chlamydia Resource Toolkit for Clinicians**

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#### **Section One: Introduction**

Chlamydia trachomatis continues to be the most frequently reported bacterial sexually transmitted disease (STD) in Massachusetts. The rate of chlamydial infections in 2003 was 181.4/100,000, and 5% higher than the 2002 rate of 172.9/100,000. Increases in rates over the last six years may be explained by enhanced screening efforts among both women and men, as well as the expanded use of new highly-sensitive diagnostic tests (nucleic acid amplification tests or NAAT). <sup>1</sup>

The Division of Medical Assistance (DMA) and the Division of STD Prevention at the Massachusetts Department of Public Health have an interest in addressing chlamydial infections for the purpose of preventing the spread of infection and preventing complications of the infection. In Massachusetts, less than 40% of sexually active women aged 25 or less are screened for chlamydia.<sup>2</sup>

#### Adolescents at risk

Throughout the years, rates of chlamydial infections in Massachusetts have remained highest among adolescents. In the year 2003, the role of infection among teens age 15-19 was 901.3/100,000, a rate that is almost five times greater than that of all age groups combined. While this data is representative of the state as a whole, rates are even higher in selected communities.

<sup>&</sup>lt;sup>1</sup>Division of STD Prevention, Massachusetts Department of Public Health, 2000.

<sup>&</sup>lt;sup>2</sup> Massachusetts Healthcare Purchaser Group - 2002 Guide to Health Plan Performance (www.mhpg.org)

1600 1400 1200 1000 800 400 400 181.4 200

Female Teens 15-19

Male Teens 15-19

Rate of Chlamydia infection for Massachusetts (per 100,000 Population)

Source: DPH Statistics 2003

All Ages

Adolescents are at the highest risk of infection for a variety of biological, social and behavioral factors. Their behaviors are often impulse driven and there is a tendency to see themselves as invulnerable to harm. For young women, their age and physiology make them more susceptible to infection because their cervical epithelial cells are developmentally immature.<sup>3</sup> These factors, along with barriers to access and the potential for recurrent infections, result in young women bearing most of the consequences of chlamydial infections.<sup>4</sup> In spite of this, most teens are still not being screened on a regular basis

All Teens 15-19

#### Why screen?

Because most chlamydial infections are asymptomatic, screening is an important component in the prevention of complications.<sup>5</sup> Outcome data has demonstrated that screening women for *Chlamydia trachomatis* can reduce the incidence of pelvic inflammatory disease by more than 50% in the course of one year.<sup>6</sup> Rates of chlamydial infections are higher among women. Until recently, screening efforts have primarily been focused on this

<sup>&</sup>lt;sup>3</sup>Sylvie Ratelle, Christie Burke, Christopher Keenan, Women and STD: The Social Context, Division of STD Prevention, Massachusetts Department of Public Health, 1994: 10.

<sup>&</sup>lt;sup>4</sup>King KH et al., "Adolescents and STDs," Sexually Transmitted Diseases, 3rd edition. S.M. Berman, K. Hein, (NYC, NY, McGraw-Hill, 1999) Ch 29.

<sup>&</sup>lt;sup>5</sup>Centers for Disease Control and Prevention, 2002 Guidelines for Treatment of Sexually Transmitted Diseases, MMWR 1998;47 (No. RR-1): 1-116.

<sup>&</sup>lt;sup>6</sup>D. Scholes et al., Prevention of Pelvic Inflammatory Disease by Screening for Cervical Chlamydial Infection, NEJM 1999;334(21): 1362-6.

population because females predominantly bear the burden of untreated infections such as pelvic inflammatory disease, infertility, ectopic pregnancy and chronic pelvic pain. Recognizing that chlamydial infections are also asymptomatic in males, screening efforts have begun in this population. Recent studies have demonstrated that screening men for chlamydia can be cost effective.<sup>7</sup>

Screening young, sexually-active women for *Chlamydia trachomatis* is recommended by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force of the U.S. Department of Health and Human Services Agency for Healthcare Research and Policy.<sup>8,9</sup> Routine screening of sexually active adolescent and young women is also recommended by the American Medical Association (AMA), the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians and several other primary care clinical specialty organizations. Furthermore, the Health Employer Data and Information Set (HEDIS) has adopted rates of chlamydia screening as a quality measure for Health Maintenance Organizations (HMOs).<sup>11</sup>

This resource Toolkit was initially created by the Division of Sexually Transmitted Disease Prevention (DSTDP) of the Massachusetts Department of Public Health (MDPH) and the DMA as part of a pilot quality improvement project which was aimed at a) determining effective ways to educate providers about the chlamydia guidelines and b) to assist providers to make changes in their practice to improve chlamydia screening, and treatment efforts. This toolkit is a second edition, and includes some of the important lessons learned from the pilot project. Its purpose is to facilitate the implementation of the *Recommendations for the Management and Prevention of Chlamydial Infections* guideline. with the following goals:

- Improve the rate and quality of sexual history taking by primary care providers for adolescents
- Increase chlamydia screening and treatment for adolescents
- Improve prevention counseling for both sexually experienced and inexperienced adolescents
- Identify and treat sexual partners of adolescents infected with a STD

By working together to achieve these goals, we can decrease the burden of chlamydial infections in the community you serve.

<sup>&</sup>lt;sup>7</sup> Ginocchio RH, Veenstrat DL, Connell FA, Marrazzo JM, The Clinical and Economic Consequences of Screening Young Men for Genital Chlamydial Infections, Sexually Transmitted Diseases, 2003:30:99-106.

<sup>&</sup>lt;sup>8</sup>Centers for Disease Control and Prevention, Take Action on HEDIS, 2000,

http://www.cdc.gov/nchstp/dstd/HEDIS.htm.

<sup>&</sup>lt;sup>9</sup>Agency for Healthcare Research and Quality, Screening for Chlamydial Infection, What's New from the U.S. Preventive Services Task Force, APPIP01-0010, March 2001.

<sup>&</sup>lt;sup>10</sup> Agency for Healthcare Research and Quality, Screening for Chlamydial Infection, What's New from the U.S. Preventive Services Task Force, APPIP01-0010, March 2001

<sup>&</sup>lt;sup>11</sup> Centers for Disease Control and Prevention, Take Action on HEDIS.

#### **Using the Toolkit**

This Toolkit is not designed to be read from cover to cover. Instead, it is designed to give your practice both resources and tips for planning and implementing activities to help improve the level of sexual history taking, chlamydia screening and treatment, partner management and prevention counseling provided to your teen patients. Throughout the text you will find highlighted sections labeled:

Key clinical issues

Offering reassurance

Office systems issues

What some teens tell us

These sections are designed to help you quickly find information or resources within the Toolkit. We are aware that many different people in a primary care practice have responsibility for ensuring that the best care is given to your patients—from physicians to the triage and office staff. Teamwork is essential to great care. Different materials in the Toolkit may have relevance to different members of your patient care team. It is your choice to decide what information gets delivered to whom.

You know best how to improve care within your practice. We suggest that you and your staff review this Toolkit and pull out the materials and tools that you think will be the most helpful in advancing your efforts to promote chlamydia screening and treatment among your teen patients. There may be things here that you already know or have expertise with. If so, skip these sections!

The Toolkit will be updated periodically as indicated by the availability of new information and/or additional resources. If you have any questions about how to use this Toolkit or our efforts to promote chlamydia screening and treatment among adolescents, please call the Division of STD Prevention, Massachusetts Department of Public Health (617)-983-6945. Good luck!

#### Additional Copies of this Toolkit can be purchased through:

The University of Massachusetts Medical School Office of Community Programs 222 Maple Ave. Shrewsbury, MA 01545 508-856-3255

## Section Two: Confidentiality and the Teen Friendly Office

Many adolescents have concerns about confidentiality, attitudes of providers and the costs related to testing for sexually transmitted diseases (STDs), all of which can prevent them from seeking information and care. In a national survey of 12,000 adolescents, 19% of teens who felt they needed care did not obtain it and at least 25% of teens engaged in risky behavior such as sexual activity also decided to forgo medical care.<sup>12</sup>

Their reasons for not obtaining care included:13

- Access barriers such as no insurance and no transportation.
- Concern with privacy and confidentiality.
- Inexperience as healthcare consumers.
- A belief that the problem would go away.

In a series of recent focus groups conducted by the University of Massachusetts Medical School with young men and women between 15 and 24 years old, additional obstacles to testing were identified as including:<sup>14</sup>

- Fear about discovering that they have a sexually transmitted disease
- Fear of acquired immunodeficiency syndrome
- A belief that it was possible to die from a chlamydial infection

It is important to create a teen-friendly office environment that addresses these barriers and concerns in order to encourage teens to access care and to be forthcoming in their communication with providers. In essence, the key to getting them the care they need is to "get them in the office door."

This section of the Toolkit offers tips on how to create a welcoming environment for teens within your office. Areas addressed include:

- Office Atmosphere and Office Hours.
- Communication
- Confidentiality
- Billing

<sup>&</sup>lt;sup>12</sup>Sean Swint, Many Teens Not Getting Necessary Medical Care, Teens at Greatest Risk Most Likely to Forgo Help, WebMD Medical News, December 14, 1999.

<sup>13</sup>Ibid.

<sup>&</sup>lt;sup>14</sup>DR Blake et al, *Improving Participation in Chlamydia Screening Programs:Perspectives of High Risk Youth*, Archives of Pediatric Adolescent Medicine, 2003, June;157(6):523-9



## What some teens tell us:15

## About the qualities they appear to trust and value most . . .

- Complete confidentiality. No chance of parent, friends or other people in the community finding out "your business."
- Friendly, non-judgmental, non-critical manner of interaction.

<sup>&</sup>lt;sup>15</sup>Massachusetts Department of Public Health (MDPH), Family Planning Division, *Teen Focus Group Survey Results*, Healthy Behaviors Campaign, 2001.

## Office atmosphere

Numerous aspects of the office atmosphere contribute to the teen's comfort level, including the familiarity of the surroundings, the attitude of the staff and the degree to which privacy is protected. To assist your office in developing an environment that is welcoming to teens consider the following recommendations:

- Assess whether your office staff is comfortable dealing with teen issues and whether
  they convey a sense of understanding of, and sensitivity to, the teen's desire for
  privacy.
- Have posters, brochures and magazines displayed in your office that cater to teens and address teen health. Ensure that these materials reflect the age, ethnicity and language of your client population.
- Place brochures and materials on sensitive topics in the exam rooms and bathroom where they can be reviewed privately. Another alternative is to have them distributed by the staff during the height/weight check or during the visit when the parent is not present.
- Choose office music for teens and ensure that conversations with the receptionist are as private as possible.
- If possible, create a separate teen waiting area and/or private area for completion of questionnaires by teens and parents.
- Request input from teens regarding what in your office practices is or is not welcoming to them.
- Make condoms available in your bathroom so that they can be obtained privately by teens.

#### Gay, Bisexual, Lesbian, and Transgender (GBLT) sensitivity 16

- Have a policy that prohibits discrimination in service delivery to gay, lesbian, bisexual and transgendered clients. Post the policy in a conspicuous location.
- Display posters with messages and/or images (rainbows) that are welcoming to GBLT teens.
- Have patient intake forms that provide space for optional self-identification of all categories of gender identity.
- Use culturally-appropriate language that is inclusive of GBLT clientele.
- Have staff trained to identify and address specific health problems and treatment issues for GBLT clients and their families.

<sup>&</sup>lt;sup>16</sup>Gay, Lesbian, Bisexual, and Transgender (GBLT) Health Access Project, Community Standards of Practice for Provision of Quality Health Services for Gay, Lesbian, Bisexual, and Transgendered Clients, November 2000, 1-7.



#### Office system issues

		Are these	recommend	lations	in	place	in	your	office?
--	--	-----------	-----------	---------	----	-------	----	------	---------

- ☐ Where are improvements possible?
- ☐ Who is the key person within the office who will address these issues?

## **Office hours**

In order to support teens in their independent efforts to seek and receive appropriate care, it is critical that they encounter as few obstacles as possible. Typically this means scheduling appointments at times convenient for teens, such as after school hours. Make allowance for same day appointments and walk-ins. Consider scheduling separate clinics that cater only to teens. Although these options can create a scheduling challenge for office staff, teens are unlikely to persist with their efforts if they encounter barriers to their attempts to seek care.

#### Office system issues

- ☐ Can your office schedule teen appointments after school?
- ☐ Can teen walk-in appointments be accommodated by your office?

## **Communicating with teens**

It is generally believed that adolescents are more likely to come to the office if they perceive that the staff is non-judgmental and that they welcome teens. When communicating with teens, consider both the communication approach and the mechanics of contacting teens.

#### Communication approach

To convey understanding and empathy with the teen consider the following suggestions:

- Anticipate possible questions or areas of confusion and go over them slowly. Teens may be afraid to speak up or may not think of questions until they leave.
- Be patient if teens have a problem filling out paperwork or understanding the payment system. Not only are they new to this, but they may be terrified about the actual visit and may not be thinking clearly.

#### Establishing an optimal plan for ongoing contact

As part of the initial intake process, the teen should be asked to identify the best mechanism(s) for communicating with him or her about scheduling future visits, reporting test results, communicating general information, etc. The preference of the teen should be visibly noted in the chart/computer, including the designation of the primary contact person and the preferred approach for reaching the person.

When developing a communication plan with teens consider the following suggestions:

- Ask the teen whether he or she would prefer to call the office for follow-up or
  whether the office should call him or her. Establish a back-up plan, including a contact person and phone number for the office to call, if the teen is supposed to call but
  doesn't.
- Establish convenient times for teens to call the office to speak with a specific staff member.
- Explore whether the teen can be reached by beeper or cell phone so that the provider does not need to call home.
- If there is no other way to communicate other than to call home, identify the best hours and ways to leave messages, including whether or not voice mail messages are acceptable. Discuss whether to have a female or male assistant call, and what to say if the teen is not home. Some possibilities are to say it is a friend called so-and-so (a name previously chosen by the teen) or to come up with some other code. Consider if the office can have the telephone number blocked so that it is not displayed on Caller ID boxes.
- Explore whether the school nurse or a school-based health center is a good resource for communicating with the teen.

Do your office systems support ongoing communication with your teen patients? Here are some suggestions to consider for improving your communication with teens:

- Develop a communication plan that identifies the best way for teens to reach the office and vice-versa. One copy can be given to the teen and the other placed in the medical record.
- Develop a tickler system to prompt staff to remind teens to schedule their preventive service visits and to monitor compliance with follow-up visits.
- Use professional appointment cards.
- Periodically mail a newsletter containing general health information to an address designated by the teen.

## Confidentiality

Teens may be distrustful of adults in general and their concerns may be heightened by the personal nature of their visit to the office. There is an important link between the teens' perception of confidentiality, their disclosure and discussion of risky behavior, and the use of health care services and information.<sup>17</sup> Therefore, explaining and adhering to a confidentiality policy is of paramount importance in eliciting their cooperation with a treatment plan.



Teens need an opportunity to meet with you without their parents and they need to know that, with few exceptions, you will not voluntarily reveal what they say to their parents or any other persons. They also need to understand in what situations you will need to disclose what they say to you and that you will work with them to decide how to inform their parents.

Ideally, at the initial adolescent visit, there should be a verbal or written contract between the physician, parent, and teen which describes the office policy regarding confidentiality and offers examples of situations where confidentiality would be maintained and broken.<sup>18</sup> A sample office confidentiality policy is located on page 9-3 of this Toolkit.

"When a patient 12 years or older is seen in our office for a physical exam, the teen/parent is given a letter from our practice advising them of our belief that adolescent patients deserve the opportunity for confidentiality (except in life-threatening situations), and a private examination. Patients/families have the opportunity to review this letter in the waiting room before seeing the doctor." 19

Most teens are unaware that, under certain circumstances, state law allows teens to obtain confidential medical treatment without parental involvement. For example, in Massachusetts teens who have, or suspect they have, an STD may consent to diagnosis and treatment for that STD.<sup>20</sup> Furthermore, the confidentiality of records from those services is protected by Massachusetts law<sup>21</sup> and parents cannot access them without the teen's consent. (One exception would be if the provider felt that the condition of the teen was so serious as to endanger life or limb.)

It is important to note that state law prohibiting disclosure supercedes the Federal HIPAA regulations, (effective 4/14/03), which generally give providers discretion to decide whether or not to disclose information to a minor's parent. However, even in states that

<sup>&</sup>lt;sup>17</sup>Jeannie S. Thrall et al, Confidentiality and Adolescents' Use of Providers for Health Information and for Pelvic Examinations, Archives of Pediatric Adolescent Medicine, Vol 154, Sept. 2000.

<sup>&</sup>lt;sup>18</sup>American Academy of Pediatrics, Ambulatory Care Quality Improvement Program (ACQIP), Exercise 2: Appropriateness of Genital Exams in Adolescent Patients, 2000, 6.

<sup>&</sup>lt;sup>19</sup>Ibid., 11.

<sup>&</sup>lt;sup>20</sup>Massachusetts General Law, Ch. 112, s. 12F.

<sup>&</sup>lt;sup>21</sup>Ibid, Ch. 111, s119.

<sup>&</sup>lt;sup>22</sup>American Civil Liberties Union, Protecting Minors' Health Information Under The Federal Medical Privacy Regulations, March 26, 2003, Summary.

do not prohibit disclosure, providers may still deny information to a parent if they believe that disclosure could result in substantial harm to the minor or another person.<sup>22</sup>

Information that is considered protected by HIPAA regulations includes any identifiable information that is created or received by a provider and relates to the physical or mental health of the individual, the provision of health care to that individual or the payment for health care. Both written and oral information is subject to the regulations.<sup>23</sup>

Does your office convey a commitment to respecting confidentiality? Here are some ideas for your office to consider when addressing confidentiality:

- Structure visit time so that both teen and parent can speak with the provider individually to discuss concerns. <sup>24</sup>
- Develop a written office policy that is shared with both the parent and the adolescent. (HIPAA requirement)
- Specify in your policy that confidentiality should be maintained both within and *outside* of the office.
- Make the policy available in the waiting room or distribute it directly to the parent and the adolescent.
- Request that both the parent and the teen sign the policy to acknowledge their receipt and understanding. (HIPAA requirement)
- Reinforce the policy verbally at each visit and explain the parameters for breaching confidentiality.
- Check to see if office staff is familiar with all aspects of the policy.
- Check to see that procedures for responding to medical record requests protect patient confidentiality.<sup>25</sup>
- When registering a teenager, do not ask him or her to state the reason for the visit if other patients are within hearing distance.
- Consider moving all phone triage staff to a location where they cannot be overheard in the reception/waiting area.

Additional resources relating to confidentiality and minor consent can be found online:

National Center for Youth Law, http://www.youthlaw.org

Advocates for Youth, http://www.advocatesforyouth.org

Society for Adolescent Medicine, http://www.adolescenthealth.org

Office for Civil Rights, http://www.hhs.gov/ocr/hipaa/

Adolescent Health Work Group, online training Confidentiality, Minor Consent and Practice Concerns When Treating Teen Patients,

http://main01.hostcast.com/custom/ahwg/ahwg.asp

<sup>&</sup>lt;sup>23</sup>American Civil Liberties Union, Protecting Minors' Health Information Under The Federal Medical Privacy Regulations, March 26, 2003, 3.

<sup>&</sup>lt;sup>24</sup> California Chlamydia Action Coalition, Adolescent Health Working Group, Confidentiality Issues in Screening Adolescents, A-5

<sup>25</sup> Ibid.

## **Billing concerns**

Billing concerns can be a significant barrier to adolescents obtaining care, especially if the teen is seeking care without parental knowledge. The concern may be related to an inability to pay for services and/or a fear that insurance notification may be sent home verifying that services were rendered.

MassHealth does not send bills and only rarely sends out confirmation of service notices to parents. This is generally the case with the Medicaid HMOs in Massachusetts as well. However, many other insurers routinely send explanation of benefit (EOB) notices to either the member or subscriber that describes the services provided. The level of detail in the EOB varies by plan - generally the visit will be described as "office visit" but the chlamydia test could be described as "lab," "NAAT," "amplified probe," "test for chlamydia" or some other variation.

Federal HIPAA regulations allow health providers, including health plans and laboratory providers, to disclose protected health information when they seek payment or make a referral for treatment. The onus is on the teens to request confidentiality and/or notices to be sent to an alternate address. This approach may place an undue burden on the teen, who may already be feeling intimidated by the fact that they are seeking treatment or being screened for an STD.

Providers can play a facilitative role with the plan by alerting the plan that the minor has been treated confidentially. This can be done by submitting a notice of confidentiality when submitting a bill for confidential services to an insurer, when sending a minor's specimens to a laboratory, and when referring a minor they are treating confidentially to another professional.<sup>26</sup> A sample confidentiality form is provided on page 9-6 of this Toolkit.

Is your office prepared to address the billing concerns of teen patients? In order to evaluate your preparedness there are several questions you and your staff can ask:

- Is our staff familiar with which insurers routinely send bills, EOBs and appointment notices to parents?
- Does our office offer teens an opportunity to pay privately, if they wish to avoid parental involvement?
- Does our office have a handout that explains billing options to teens and asks them to choose a preferred approach?
- Does our office have a policy on waiving payment for teens?
- Does our office have a notice of confidentiality that is routinely submitted with lab requests and/or referrals associated with treatment provided confidentially?
- Does our office have information on local family planning services or STD services that could provide State/Title X-funded services confidentially if need be?

<sup>&</sup>lt;sup>26</sup> American Civil Liberties Union, Protecting Minors' Health Information Under The Federal Medical Privacy Regulations, March 26, 2003, 12.

## Section Three: Cultural Issues That Affect Diagnosis and Treatment

As population demographics of the U.S. continue to change, health care providers of the 21st Century will care for a more culturally diverse population with a variety of beliefs and practices about health, illness and treatment. Socio-cultural differences among the diverse population groups will have implications for the care and management of chlamydia and other sexually transmitted diseases.

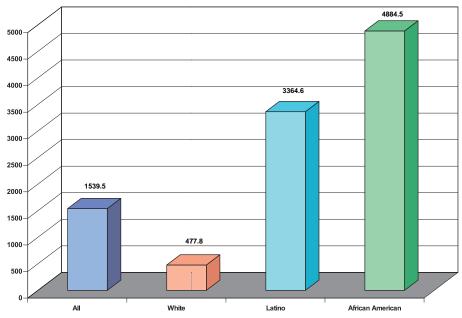
This section of the toolkit provides information on:

- Racial/ethnic variances in chlamydia prevalence rates
- The role of culture in care
- Assessing the influence of cultural background
- Culture-specific insights

# Factors affecting chlamydia prevalence

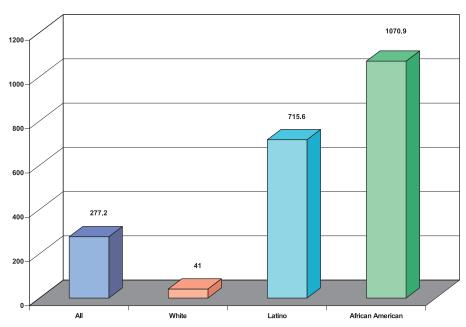
There are significant variances in prevalence rates for chlamydia among racial and ethnic teen populations.

Chlamydia Prevalence Among Massachusetts Female Teens Age 15-19 (per 100,000 Population)



Source: DPH statistics 2003

Chlamydia Prevalence Among Massachusetts Male Teens Age 15-19 (per 100,000 Population)



Source: DPH statistics 2003

Some of the factors that may contribute to the rate differences of chlamydia infections among specific populations include:

•	Differences in sexual activity/practices
	☐ Age of first sexual intercourse
	☐ Level of sexual activity
	☐ Number of sexual partners
	☐ Condom use
•	Differences in cultural health beliefs/practices between the practitioner and
	the patient
•	Barriers to access
	☐ Language differences
	☐ Lack of insurance or transportation
	☐ Knowledge of U.S. medical system
•	Socioeconomic status (SES)
	☐ Low SES is associated with decreased use of preventive health services which
	contributes to less risk factor reduction, more complications and
	increased morbidity.
•	Organizational systems limitations for supporting cross cultural care

#### Role of culture and care

"Culture refers to a set of learned beliefs, attitudes, and behaviors attributed to a specific group of people who share a common life experience. Culture formulates one's understanding of the world and one's explanation of health and well being. Culture also facilitates interactions among persons from the same culture but may hinder understanding among culturally different persons.<sup>27</sup>"

Cultural factors can affect the adolescent's health care practices in several ways:<sup>28</sup>

- Cultural beliefs about health and illness may influence how a problem is described by adolescents.
- Cultural beliefs and values may influence adolescents' perception of the effectiveness of a treatment and their willingness to comply with treatment.
- Adolescents may fail to discuss or disclose important information because of cultural beliefs about what types of problems require medical attention or what types of problems may be discussed with non-family members.
- Self-disclosure for any adolescent is a delicate matter and may be further complicated by the presence of a translator and the nature of that individual's relationship to the patient, family and community at large.

<sup>&</sup>lt;sup>27</sup>American Medical Association, Guidelines for Adolescent Preventive Services (GAPS) Implementation and Resource Manual, 1995: 32.

<sup>&</sup>lt;sup>28</sup>Ibid., 33-34.

Provider knowledge and awareness of the socio-cultural aspects of health behaviors will impact care management practices and patient outcomes. Differences in cultural health beliefs/practices between the health care provider and the teen can result in:

- Inadequacies in the provision of care unless common understanding is achieved
- Biased clinical decision making by the provider and recommendations for inappropriate therapeutic regimes
- The teen having difficulty adhering to a treatment plan
- Teen dissatisfaction with the overall healthcare experience

Examples of how miscommunication and misunderstanding play out:

#### Teen

- "I didn't understand what the doctor said."
- "He/She didn't listen to me. He/She didn't tell me in a way that I could understand."

#### Provider

- "The patient didn't do what I asked them to."
- "This patient won't benefit from this treatment or test because they don't understand it."

## Assessing the influence of cultural background

The social/cultural health practices among racial and ethnic populations contribute to the differences in behavioral outcomes and may contribute to the statistical differences in the chlamydia prevalence and risk behaviors. Teens from diverse racial and ethnic populations may be significantly affected by the values, attitudes, beliefs and behaviors of their families and their communities.

In relation to the screening and treatment for chlamydia, a teen's cultural background may influence how the following issues are viewed:

- Same gender sexual activity
- Discussion of sexual issues
- Gender roles in relationships
- Appropriateness of gender of the provider
- Use of folk cures
- The value of pregnancy

Therefore, an important step for the provider is to assess the degree to which the teen's cultural background is a predominant influence in his/her life. To promote optimal care to teens from different cultures, the provider must develop a culturally competent and sensitive approach to care which in some instances may include a cultural assessment.

"Because issues surrounding sexually transmitted diseases are so personal and may evoke strong emotional reactions, the challenge of providing culturally competent care is even more critical for providers of STD services.<sup>29</sup>"

The cultural assessment process uses a systematic approach to elicit patient views on health, illness, communication, and decision-making styles. The goal is to clarify the nature of the problem and modify intervention and treatment goals specific to the condition being treated. The following questions developed by Arthur Kleinman, M.D. have been recommended for use as a basic script during the clinical encounter to elicit how the patient perceives his/her problem and what expectations he/she may have from the visit.

#### Eliciting Patients Health Beliefs<sup>30,31</sup>

- What do you call your problem? What name does it have?
- What do you think causes your problem?
- Why do you think it started when it did?
- What is your sickness doing to your body? How does it work?
- How severe is it? Will it have a short or long course?
- How has this sickness affected your life? What problems has it caused you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

<sup>&</sup>lt;sup>29</sup>Ratelle et al., Women and STD: The Social Context, 1994, pp. 37.

<sup>&</sup>lt;sup>30</sup>Lillie-Blanton M, Rushing OE, Ruiz S. *Key Facts: Race, Ethnicity and Medical Care*, N.P. Henry J. Kaiser Foundation. 2003 <sup>31</sup>Buchwald, D., Panagiota, C., Gany, F., Hardt, E., Johnson, T., Mueke, M. and Putsch, R., *Caring for Patients in a Multicultural Society*, Medical Care, pp. 90-116, 1996.



## Offering Reassurance

"Generally when I am treating patients I ask personal questions regarding sexual practices. I want to be sensitive to your cultural beliefs and practices. Is this approach appropriate in your culture? Is it ok for a male/female to examine you?"

"I want to make sure you are comfortable during your exam. In your culture, are male or female health providers preferred? Do you have any concerns with me examining you today? If so, please share them with me. I am learning too and the information you give me will only help me give you the best care possible."

It is important for providers to keep in mind that teens from the same cultural group may not hold the same values and a teen's cultural values may or may not be factors in the way they respond to your efforts. When caring for patients from a cultural background different than your own, consider the following variables:<sup>32,33</sup>

- Individual characteristics
- Recent immigration to the USA
- Lack of or limited formal education
- Socioeconomic status
- Residential segregation
- Segregation in an ethnic subculture in this country
- Inexperience with Western health care systems
- Major differences in language, dress, knowledge, attitudes, beliefs, behaviors and practices

#### Also consider the following:

- Your own knowledge, attitudes, beliefs, values and practices as well as those of your practice
- Your own familiarity with the teen's cultural beliefs and practices
- What modifications are indicated in your communication and treatment approach with the teen?
- What modifications are indicated in your communication with the accompanying parent?

<sup>&</sup>lt;sup>32</sup>Lipkin, et al., *The Medical Interview, American Academy of Physicians and Patients*, NY, Springer, 1995. <sup>33</sup>Ibid.

#### Negotiating treatment and disease self-management

Negotiating treatment with an adolescent in a cross cultural encounter first involves an acknowledgment by the patient and the practitioner that there may be differences, and in some cases, lack of congruency between their belief systems<sup>1</sup>. I Patients are less likely to adhere to interventions that are not congruent with their own health belief system. The practitioner can often reach a compromise with the patient by presenting the problem of Chlamydia in terms and concepts that reflect the patient's views and/or respect the patients' belief system. Treatment negotiation can then focus on explaining:

- Why a specific medication regime is recommended,
- The importance of taking and monitoring medication use,
- How the treatment will affect daily functions,
- How the family will be impacted,
- How culturally specific practices may be modified.

Negotiations can also include those interventions believed by the patient to be helpful as long as these interventions are clinically safe.

## Culture-specific insights<sup>34</sup>

Some general information is available about the cultures of selected racial and ethnic populations and the possible implications of this information for diagnosis and treatment of Chlamydia. However, very little data exist which describes teen culture and sexuality for each of the U.S. government defined population groups.

#### **Key Clinical Issue**

There is often more diversity within ethnic/racial groups than between them. Therefore, it is important not to stereotype, over generalize or characterize all members of a cultural group as being alike.

<sup>&</sup>lt;sup>34</sup>Ratelle et al., Women and STD: The Social Context, 1994, pp.25-36.

#### Black/African-American

#### Beliefs/values

- Sexuality is viewed as a natural and positive part of life
- Homosexuality is taboo
- Emphasis on birth as a continuation of the race
- Highly acculturated to the use of medical care
- Extended family is very important
- Some girls believe that not having sex will end their boyfriend relationship

#### Treatment implications:

- Recommendations for use of barrier methods may be viewed with suspicion.
- Homosexual men may also engage in sex with women, placing the women at greater risk.
- Family support can be encouraged.

#### **Asian-Americans**

#### Beliefs/Values

- Much diversity among the 30 ethnic groups.
- Open expression of any sexuality is not condoned in public; homosexuality is not viewed favorably.
- Sexual discussion is taboo among some groups.
- Sexual repression is expected so as to avoid dishonoring family.
- Stoicism and control of emotions is highly valued.
- Decorum, propriety and modesty are highly valued.
- The family and its welfare are more important than that of the individual.
- Illness may be classified by a cold/hot dichotomy, perceived of as an obstruction of the life energy, or seen as an unavoidable part of life.
- Wide range of herbal and folk cures may be used, some of which may leave marks on the body.

#### Treatment implications:

- It may be important for an Asian woman to have a female provider.
- Teens may not ask questions and may signal that they understand and agree with what is said, even when they may not.
- Fear of bringing shame may make it difficult to obtain treatment; this may be mitigated by stressing confidentiality and the degree to which treatment will help them fulfill their current or future family role.
- Homosexual men may also be engaging in sex with women, placing the women at greater risk.

#### Haitian-American

#### Beliefs/Values

- Feeling of shame relating to sexual issues for women.
- Non virgins may be considered unmarriageable.
- Homosexuality is not commonly accepted.
- Illness results from an imbalance of hot and cold factors relating to food and temperature; some believe illness can be of supernatural origin.
- Parental authority is respected; role of mother is central to family's well being.

#### Treatment implications:

- A female provider may be preferable
- Women are less likely to report rape or symptoms of STDs
- Request of condom use could result in accusations of faithlessness
- Homosexual men may also be engaging in sex with women, placing the women at greater risk
- Stress the importance of receiving treatment to preventing infertility
- Explain antibiotic treatment in the context of hot/cold theory

#### Latino

#### Beliefs/Values

- Sex is never discussed within the family, except in general terms.
- Strong heterosexual influence and high degree of homophobia Sex outside of the main relationship is tolerated.
- Children and fertility are highly valued.
- Family is the central social unit and source of support; men perceive themselves as responsible for the well-being of loved ones.
- Strong need for relationships built on trust, respect, pride and dignity.
- Respect for age and authority; information provided by an authority will not be questioned.
- Some believe in hot/cold theory of disease; some believe illness is beyond individual control.

### Latino (continued)

Treatment implications:

- Some adolescents seek pregnancy; this will conflict with the use of barrier methods.
- Partner insistence on condom use or treatment is seen as inappropriate because it challenges personal dignity; better to direct messages to women/men individually.<sup>35</sup>
- Emphasize need for females to take seek treatment in order to prevent infertility.
- Emphasize to men the risk to loved ones of infection and complications.
- Homosexual men may also be engaging in sex with women, placing the women at greater risk.
- Ask teens to tell you "in their own words" the instructions you have given them.
- Expectation that providers will ask about and remember details about family.
- Explain antibiotic treatment in the context of hot/cold theory.

## **Office System Issues**

Is staff comfortable serving patients from other cultures? What level of
cultural awareness exists among your providers?
What resources are needed to help you with these efforts?
Do your intake and sexual history forms request information on cultural
beliefs/practices and language spoken?
Does your office have culturally appropriate patient language materials
that are written at the literacy level the patient can understand?

Does your office have or need interpreter services?

☐ What resources are available within your office or community for addressing the needs of patients from another culture?

<sup>35</sup> Lillie-Blanton M, Rushing OE, Ruiz S. Key Facts: Race, Ethnicity and Medical Care, N.P. Henry J. Kaiser Foundation. 2003

## **Section Four: Sexual History Taking**

The American Medical Association (AMA) recommends in its Guidelines for Adolescent Preventive Services (GAPS) that sexual history taking be performed annually for all adolescents.<sup>36</sup> The need to take the sexual history of adolescents is further supported by a 2001 Massachusetts Department of Education survey which revealed that 44% of all high school students have had sexual intercourse, including 28% of 9th graders and 65% of 12th graders.<sup>37</sup> This section of the Toolkit offers suggestions on how to address traditional barriers to sexual history taking and includes what questions to ask and how to ask them.



## What some teens tell us:38

About why they are reluctant to talk about sexual information, issues or behaviors with health providers . . .

- Distrust that their personal health information would be kept confidential.
- Embarrassment about what other people would think or say about them if they openly talked about sexual relationships, experiences or health care needs.

<sup>&</sup>lt;sup>36</sup>American Medical Association, Guidelines for Adolescent Preventive Services (GAPS), *Recommendations Monograph*, 1997, 5.

<sup>&</sup>lt;sup>57</sup>Massachusetts Department of Education, *Massachusetts Youth Risk Behavior Survey (MYRBS)*, 2001. www.doe.mass.edu/hssss/yrbs/01/results.pdf.

<sup>&</sup>lt;sup>38</sup>MDPH, Teen Focus Group Survey Results.

## Barriers to sexual history taking

Input from local opinion leaders suggests the key obstacles to sexual history taking within primary care practices are:

- Lack of private, soundproof space.
- Lack of provider experience or discomfort with asking questions.
- Provider discomfort or inability to respond to issues that arise, such as sexual abuse.
- Provider uncertainty on how to make the teen comfortable, particularly with regard to discussing same-sex relationships.
- Brevity of office visits.
- Lack of reimbursement.

Some steps for addressing these barriers include:

- Developing a practice policy for when and where sexual history taking will be initiated.
- Determining how this will be integrated into the overall care of the teen.
- Identifying the specific questions that will be asked.
- Developing a plan to respond to the information that might surface.
- Training staff in how to perform sexual history taking.

#### Deciding whether or not to refer out

Not all providers are comfortable performing sexual history taking. Your office will need to decide whether your teen patients would be better served by having your staff perform this function or by referring the teens to another provider. The most important issue is that you ensure that this service is provided to teens on a regular basis. (Some teens may already be going elsewhere for STD screening as State/Title X funded organizations provide statewide access to family planning services without referral.) In order to determine the best approach for your practice consider the following:

- Clarify with each teen whether or not he or she is obtaining this service elsewhere and, if so, where.
- Assess the level of comfort of your clinical providers in performing sexual history taking.
- If some clinical providers are not comfortable, provide or recommend training. Determine whether is it possible to designate one or more individuals within your practice to perform this function.
- Determine whether your office needs to establish a link with a local GYN practice, adolescent/teen clinic, STD clinic or family planning center to handle the sexual history taking and GYN aspects of teen care. If so, determine whether you have a system in place for tracking whether care was received and for ongoing communication with the referral provider.

## When to initiate sexual history taking

Provider practices vary in relation to when sexual history taking is started. Often the decision on when to start is based on the developmental maturity of the teen.

#### Key clinical issue

Sexual history taking should be part of the health assessment of every teen regardless of his/her educational and socioeconomic status. The AMA Guidelines for Adolescent Preventive Services recommends that sexual history taking begin at age eleven.<sup>39</sup>

Sexual history taking can be performed within the context of:

- a mandatory well-visit exam.
- school, sports or camp physicals.
- a sick visit when the patient presents with signs and symptoms associated with the presence of an STD.
- a visit related to reproductive or family planning issues; e.g., seeking contraceptives or a pregnancy test.
- any sick visit if the teen has missed his or her annual exam.

These opportunities allow for the sexual history taking to be integrated into the overall physical exam. This allows for a less threatening introduction to the discussion with the teen. When included in every physical, the intention is for the teen (and provider) to become more accustomed to the nature of the questions.

#### Incorporating sexual history taking into the acute care visit

Since 55% of MassHealth teens do not schedule or keep their preventive well-visit appointments,<sup>40</sup> the healthcare provider may, by necessity, need to incorporate sexual history taking into an acute visit. Although this may not be ideal due to time constraints, if not attempted, the acute care visit becomes a missed opportunity for the health care provider to begin this important information gathering process. Even if all that is incorporated into the acute visit is a few sexual history questions or a discussion of the need to schedule a well-visit, it will set the stage for further discussions.

Conversely, it may be that the teen was previously examined and treated for a STD but did not return for follow-up care. In this instance, during the new, acute care visit, the health-care provider will have an opportunity to integrate the follow-up care pursuant to the previous encounter.

<sup>&</sup>lt;sup>39</sup>GAPS Recommendations Monograph, 2.

<sup>&</sup>lt;sup>40</sup>Massachusetts Department of Medical Assistance, MassHealth Data, 1999.

## Creating an environment conducive to sexual history taking

#### **Developing trust**

As teens transition from childhood to adolescence, their relationship with their healthcare provider will also transition, with the teen becoming the primary point of contact and communication with the provider. Accordingly, the teen will assume an increasingly independent role in decisions regarding his or her own health. The teen's willingness to communicate openly with the provider will be dependent on the level of trust that has been established.

#### Offering reassurance

To help set the stage for this transition consider including the following points in your communication with teens:

- The importance of the teen developing a trusting relationship with the healthcare provider and the role of the provider as an advocate.
- Good medical care can only be provided if you have accurate information about the teen's problems.
- The teen can speak with you confidentially and these conversations are protected in some situations by law.
- You respect parents' opinions but what you are most interested in is what the teen tells you.

"Once you can open up a 'one on one,' trusting attitude, you can begin to focus on the actual healthcare.41"

In order to create an environment where the teen feels comfortable responding to sensitive questions, both **privacy** and **confidentiality** must be established at the outset. Yet many teens are never given the opportunity to meet privately with their providers and as a result, they may withhold important information about their health. In a 1997 survey of 6,728 adolescents, 40% said they did not have an opportunity to talk with their doctors alone during an office visit and 35% said they did not receive care for a health problem because they did not want their parents to find out about it.<sup>42</sup>

In order to provide effective care, teens must be given the opportunity to speak with the provider alone. Parents must be given an explanation of why this is necessary and reassurance that they will also have an opportunity to discuss their issues and concerns about the teen with the providers.

#### What some teens tell us:

"If my mom is there, I'm going to have to lie, duh . . . 43"

<sup>&</sup>lt;sup>41</sup>Tom Berson, Teens Face Barriers When it Comes to Health Issues, The Daytona Beach Sunday News Journal, June 25, 2000.

<sup>&</sup>lt;sup>42</sup>Florida Commonwealth Fund, Survey of the Health of Adolescents, 1997.

<sup>&</sup>lt;sup>43</sup>Berson, Teens Face Barriers When it Comes to Health Issues, The Daytona Beach Sunday News Journal, June 25, 2000.



#### Offering reassurance (to parents)

"Mrs. Smith, in order to provide the best care for Jennifer, my plan for today's visit is to meet first with both you and your daughter, then privately with Jennifer, and then privately with you if you desire. This way I can address each of your concerns and at the same time, recognize Jennifer's growing independence by assuring her the same level of privacy that I offer adults. 449

#### While parents are still in the room

- Distribute a copy of your confidentiality policy if you have not already done so.
- Ask general questions about family history, recent illnesses or problems since the last visit.
- Ask the parents and teen if anyone has any concerns that they want to share at this time.

#### If the partner has accompanied the teen

- Utilize an approach similar to that used with a parent, emphasizing your interest in meeting first with the teen and the partner, and then with the teen alone.
- Offer positive reinforcement to the partner for accompanying the teen to the visit.
- Stress your commitment to confidentiality.
- If appropriate and with the teen's permission, include the partner in education/counseling discussions.

#### After the parent leaves the room

• Reinforce confidentiality.

#### Offering reassurance

"John, now that you are a teenager, you are old enough to have your own relationship with a provider. There are things that you may want to share with me that you don't want discussed with anyone else. I want to assure you that I will not voluntarily tell your parents or any other person what you say to me unless there is a safety issue, like your hurting yourself or someone else, or if I am required by law to report something."

• Begin the interview informally and lead gradually to the sexual history.

"The patient should feel that he or she is on common ground with the physician during this portion of the visit by being fully dressed and in a comfortable chair to allow for a measure of control and comfort.<sup>45</sup>"

<sup>&</sup>lt;sup>44</sup>STD/HIV Prevention Training Center of New England, *Approach to Sexual History Taking and STD Screening*, Self Study Module One, December 1, 2000, 35.

<sup>&</sup>lt;sup>45</sup>American Academy of Pediatrics, ACQIP, 2.

• Use the HEADS model to start asking about home, education, activities and friends before moving to more sensitive topics (such as drugs/depression/dating/sex). Sample HEADS questionnaires are included in Section Nine of this Toolkit.

#### Offering reassurance

"I am going to ask you some questions that are personal and some of which may be embarrassing, but this helps me provide better care for you. I want you to know that I ask everyone these questions and I ask them in a specific order so that I have a clear picture of your medical needs. People have sex in different ways and at different ages and I want to be able to talk about that with you."

#### • Remember the basics:

- 1. Be sure that the teens know what you are asking. Be very concrete. Sexual activity means different things to different people.
- 2. Use third person references, such as "What are your friends doing?"
- 3. Don't assume anything in terms of what the teens do or how they appear.
- 4. Don't act surprised, shocked or embarrassed by the answers you get. Body language and non-verbal communication are very important in conveying your comfort level.46
- 5. Never assume heterosexuality. Use gender neutral terms in referring to (potential) partners.
- 6. Watch the reaction of the teen for cues on when he or she is uncomfortable and when to move on.

In order to establish open communication with adolescents it is important that your questions and explanations:

- Are clear, straightforward, matter of fact and non-judgmental.
- Are tactful and culturally sensitive.
- Are worded using simple language rather than medical terminology or euphemisms.
- Avoid using the word "should" as it is difficult to keep a dialogue going if teens feel they are being lectured to.47
- Offer feedback that identifies strengths, as well as correcting inaccurate information.<sup>48</sup>
- When the teen shares information, congratulate him/her on thinking responsibly about his/her sexual health.49

You will be more likely to elicit their participation if you use open-ended questions and express interest in what is being said. Make sure to repeat the essentials and leave ample time for questions.

<sup>&</sup>lt;sup>46</sup>STD/HIV Prevention Training Center of New England, 12.

<sup>47</sup>Ibid., 46.

<sup>48</sup> Ibid., 107.

<sup>49</sup>Ibid., 46.



# Key clinical issue

The goal of the interaction is to keep the communication channel open and to keep the teen coming back for follow up. If you are encountering a lot of resistance, back off and defer other questions to future visits, but keep a record of where you left off.

# Questions to include in sexual history taking

The questions asked should be tailored to the developmental phase of adolescence. For instance, if the teen has not reached puberty you might focus on what to expect during puberty. If he or she is already past puberty, you will want to ask about the menstrual cycle and how it relates to reproduction; sexual activity and how it relates to dating, relationships and pregnancy; whether he or she is sexually active; and knowledge about birth control.

For girls, ask about menstrual history first, and then follow with questions about sexual history, such as:

- What are you learning in health class?
- Have you learned about sexual development?
- What have you learned in school or elsewhere about STDs and birth control?
- What are other kids doing? Are you hearing about other kids having sex?
- Do you date? Tell me about them? How old? Does he/she work or attend school? What kinds of things do you enjoy doing together? How is he/she treating you?
- What questions or concerns do you have about sex?
- Are you having or have you ever had sex?

### If the reply is "no"

"I'd like to make sure I understand your answer. People have sex in many different ways. By sexual activity, I mean to ask if you are having any oral, vaginal or anal sex. 50"

- Have you thought about what you might do if you ever felt pressure to have sex?<sup>51</sup>
- Are you thinking about having sex with anyone in particular?

"Just in case you are thinking about it or have any questions, I am always available to discuss your questions and concerns. Please remember that I am here to support your decision."

• Do you sometimes have sexual feelings for someone of your own sex?<sup>52</sup> If yes, can you tell me more about that?

### If the reply is "yes"

- Tell me about your partner or partners? How long have you been together?
- Does your partner(s) have other sexual partners?
- Do you have sex with men, women or both?
- What are you using for contraception? Have you ever been pregnant or responsible for someone becoming pregnant?
- What kind of sex? Vaginal? Anal? Oral? (Depending on response, may need to specify penis to vagina? Penis to mouth? Penis to anus? Mouth to penis/vagina/anus? Receptive or insertive?)

<sup>&</sup>lt;sup>50</sup>STD/HIV Prevention Training Center of New England, 18.

<sup>&</sup>lt;sup>51</sup>Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, *Middle Adolescence 15-17 Years*, 266. <sup>52</sup>Ibid.

"I would like to ask you some questions about risky behavior, because there may be information I can offer you that will help you reduce your risk of illness or injury..."

- How many partners have you had in the past 12 months?
- Any new partners is the last 2 months?
- Do you use condoms? Never, sometimes, always? With what types of sex? Have you ever had one break?
- Does your partner use condoms with his/her other partners?
- When was the last time you had unprotected sex?
- Have you ever had sex under the influence of drugs or alcohol?
- Have you ever exchanged drugs or money for sex?
- Has anyone ever touched you in a way you didn't like or forced you to have sex?<sup>53</sup>
- Review past STDs and document the number of episodes and when last treated.

### What providers tell us:

- "When asked if she was sexually active, the teen replied, "no, I don't move around much."
- "When asked if she had had sex, the teen replied, "I am not sure." The provider said, " either you have had intercourse or you haven't." She replied, "what's intercourse?"
- "When asked if his partner used contraception, he replied, "yes, I give each one the pill before we have sex."

### What some teens tell us:

"When you asked me if I was sexually active, I thought you meant now, not three months ago  $\dots$ "

"Well, I didn't mention him before because he's not really a boyfriend . . ."



### Key clinical issue

Alcohol and drug use play a central role in the sexual activity of many adolescents, thus placing them at higher risk of engaging in sex, particularly unprotected sex, and getting STDs.<sup>54</sup>

<sup>&</sup>lt;sup>53</sup>Bright Futures, 266.

<sup>&</sup>lt;sup>54</sup>STD/HIV Prevention Training Center of New England, 108.



# Key clinical issue

Because older males tend to have or have had multiple sexual partners, female teens who have older male sexual partners are at higher risk for chlamydia infections and other STDs.



# Key clinical issue

Anal intercourse may be used by some heterosexual teens as a way to preserve virginity and protect against pregnancy.<sup>55</sup>

<sup>&</sup>lt;sup>55</sup>STD/HIV Prevention Training Center of New England, 108.

### Addressing issues of sexual abuse

When taking a sexual history, it is a good idea to first remind your patients about confidentiality regarding the information they will impart with the exception of sexual or physical abuse so that they know what they can expect. If the teen answers "yes" to questions such as "Has anyone ever hurt you physically or sexually?" or "Has anyone ever touched you in a private place that made you uncomfortable?" it is important to remind him/her that you are mandated to report this (51A). Once you have explained this, you can then proceed to ask details about the event such as:

- What happened?
- Who did this to you?
- When did it happen?
- Has it ever been reported?

Your responses will be determined by what the patient says. Your objective is two-fold-to fulfill your reporting obligations and to keep the trust of the patient. Let the teen know that it isn't his/her fault and to offer counseling and/or referral. You may need to talk with the parent too, depending on the circumstances. Referral resources for sexual abuse are located in Section Eight of this Toolkit.

"I let the patient know about reporting and give them the control to tell me what they want to tell me. I will invite them back and it may take several visits before they will tell me the whole story."

# **Charting sexual history taking**

Charting systems can be a major barrier to documenting sexual histories. Office practices vary in how to handle charting of sexual history taking and each system has its benefits and limitations. Some keep all patient information in one centralized record which is convenient for providers but potentially problematic for limiting parental access. Others create a shadow record or separately designated section of each record (for example, records relating to the treatment of a



suspected STD) for recording confidential information that is not available for review by parents. This method requires providers to review two charts and could lead to overlooking important information. (An example of this could be the prescribing of a medication that renders birth control pills ineffective because the information about birth control pills was contained in the shadow record.) Yet others use abbreviations or codes for laboratory results and diagnostic information. An example of such abbreviation might be the use of SU to denote sexually active, unprotected sex.<sup>56</sup> This system can create problems in that the coding system may be too complex or may not be used by everyone in the practice so it may be difficult for others to decipher.

Your practice will need to consider how much detail to include in the patient record and how to best protect the confidentiality of this information. Some questions to ask to help determine what is best for your office include:

### Office system issues

- ☐ Do your patient history forms incorporate questions regarding sexual history? If not, how will you document that a comprehensive sexual history has been obtained?
- ☐ Do your patient history forms provide for optional self-identification in all categories of gender identity, sexual orientation, marital, partnership and family status and provide clients with the option and opportunity for further written explanation?

<sup>&</sup>lt;sup>56</sup>Society of Adolescent Medicine, Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine, Journal of Adolescent Health, 1997: 21: 408-415.

# **Section Five: Providing Prevention Counseling**

Despite the increased risk of STD infection among teens, many of them are unaware of the factors that place them at risk. One recent national survey of sexually experienced 15-17 year olds revealed that:<sup>57</sup>

- 40% do not consider themselves at risk for STDs.
- 70% have never been tested for STDs, with the exception of some testing for HIV.
- 40% do not always use condoms.
- 55% have not discussed STDs with their current or most recent partner.
- 57% have never discussed STDs with a health care provider.

Primary care physicians are in a position to play a critical role in prevention counseling. Teens may see their physician as their most reliable source of health information and so in some cases the primary care physician may be the only adult with whom the teens can confide their problems. The American Medical Association recommends that physicians and other health professionals provide health guidance annually to adolescents regarding responsible sexual behaviors, including abstinence.<sup>58</sup> They further recommend that latex condoms to prevent STDs and birth control be made available, as well as instructions on how to use them effectively.

This section of the Toolkit offers suggestions on what content to include in your patient education messages, how to provide effective counseling and how to get teens to listen to your advice.

### What some teens tell us:59

### About what works to make them aware of risks...

- "Real-life" stories and testimonies.
- Emphasizing the threatening short and long-term effects STDs can have on physical health, appearance and future pregnancies.
- "Straight up" information realistic, direct and straight-forward information about STD symptoms and types of treatment available.

### About talking to their partners about STDs...

"It's embarrassing to bring up STD questions with a girlfriend because she might think you have one."

"A lot of boys I know aren't thinking about STDs, they're thinking about pregnancy first. An STD, they think, 'I can cure it.' If she gets pregnant, that baby is there for life."

<sup>&</sup>lt;sup>57</sup>The Kaiser Family Foundation/MTV/TEEN PEOPLE, National Survey of 15-17 Year Olds: What Teens Know and Don't Know (but should) About Sexually Transmitted Diseases, 1999.

<sup>&</sup>lt;sup>58</sup>GAPS Recommendations Monograph, 4.

<sup>&</sup>lt;sup>59</sup>MDPH, Teen Focus Group Survey Results.

# Content to include in patient education messages

The AMA Guidelines for Adolescent Preventive Services (GAPS) suggest that the following health guidance for sexual responsibility be offered to adolescents:<sup>60</sup>

- Counseling that abstinence from sexual intercourse is the most effective way to prevent pregnancy and STDs, including HIV.
- Counseling on how HIV is transmitted, the dangers of the disease and the fact that latex condoms are effective in preventing most STDs including HIV.
- Reinforcement of responsible sexual behavior for adolescents who are not currently sexually active and for those who are using birth control and condoms appropriately.
- Counseling on the need for adolescents to protect themselves and their partners from unwanted pregnancy and STDs, including HIV and exploitation.

The providers in your office may want to include the following messages, developed by the Massachusetts Department of Public Health STD program, in your prevention counseling efforts:<sup>61</sup>

- While abstinence is the most effective way to avoid STDs, the kinds of sexual activity that do not include vaginal, anal or oral intercourse are also "safer" sex and less likely to spread STDs, such as dry kissing, touching, hugging and massage.
- You can limit your exposure to STDs by having sex with only one person if they also are only having sex with you and they are uninfected.
- Use condoms correctly and consistently every time you have sex.
- Look at your partner's body and if you see any signs of STDs, like rashes or sores, do not have sex!
- Limit alcohol and other drugs that may cause you to take chances you might otherwise not take.
- If you plan to be sexually active, learn all you can about STDs and be prepared with condoms, barriers and birth control.
- If you think you are infected, avoid any sexual contact and visit your doctor, a local STD clinic, or hospital for evaluation.

Additional educational materials to support your counseling efforts are located in Section Ten of this Toolkit.

<sup>60</sup> GAPS, Recommendations Monograph, 4.

<sup>&</sup>lt;sup>61</sup>The Massachusetts Department of Public Health, Sexually Transmitted Disease Program, Sexually Transmitted Diseases Information and Assistance Handout.

# How to provide effective prevention counseling to adolescents

Providing effective behavioral counseling can be challenging, especially when dealing with adolescents. Although a thorough discussion of the methods and counseling strategies used (such as stage of change/transtheoretical model) is beyond the scope of this Toolkit, certain elements are key for effective counseling:

- Reinforce your policy on confidentiality.
- Use open-ended questions.
- Engage the adolescent in a dialogue and focus on his/her personal risk and circumstances.
- To aid comprehension, avoid using terms such as probably, possibly and likely when communicating health risks and instead use numerical expressions of uncertainty (e.g., 3 in 10 chance).<sup>62</sup>
- Help the teen to set and reach specific goals.
- Avoid lecturing and be non-judgmental.
- Acknowledge and compliment the teen on any positive attempts at risk reduction.
- Avoid confrontation and acknowledge that change can be difficult.
- Individualize your approach based on the teen's readiness to change. If they seems to be pre-contemplative, start with story telling and information giving.<sup>63</sup> If they are in an action mode, give support and reinforcement. Don't make the teen feel guilty.

In addition to providing education regarding risks and prevention efforts, teens need help developing the interpersonal skills to resist unwanted activity and to obtain or advocate for the use of protective measures.<sup>64</sup> A handout on dialogue for encouraging condom use by partners is located in Section Ten of this Toolkit.

### What to say to teens feeling pressured to have sex:

"Having sexual feelings is normal, but the decision to have sex should be well thought out. It's important to put off having sex until you're ready to handle the responsibilities that go along with it. If your partner really cares about you, he/she won't push you into doing something you're not comfortable with. "5"."

### What to say to teens whose partner(s) won't use condoms:

"You say that your boyfriend won't use a condom . . . how might you tell him that this is important to you?"

- "I really care about you but I don't want to get pregnant."
- "I talked to the doctor about STDs and by using condoms, we can prevent them."
- "If you really love me, use a condom."
- "No condom, no sex!"

<sup>&</sup>lt;sup>62</sup>LD Cohn et al., Adolescents' Misinterpretation of Health Risk Probability Expressions, Pediatrics 1995 May; 95 (5): 713-6.

<sup>&</sup>lt;sup>68</sup>Coury-Doniger PA, Levenkron JC, Knox KL, Urban MA, From theory to practice: use of stage of change to develop an STD/HIV behavioral intervention, Cognitive and Behavioral Practice 2001; 7: 395-406.

<sup>&</sup>lt;sup>64</sup>Ratelle, et al, Women and STD: The Social Context, 12.

<sup>&</sup>lt;sup>65</sup>Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, *Middle Adolescence* 15-17, 275. http://www.brightfutures.org

# Getting teens to listen to and accept educational advice

Some suggestions your office may want to consider in order to help get teens to listen to educational advice include:

- Use simple terms and avoid the use of complex medical terminology and jargon.
- Use visual aids when available like charts, posters, diagrams and anatomical models.
- Start out by assessing what the teen knows and having a dialogue, filling in the gaps in his/her knowledge. Find out what s/he wants to know, then move into what s/he needs to know once the conversation has gotten going.
- If the teen is knowledgeable, give positive feedback on all that s/he knows.
- Address the tendency for teens to think that the problem will go away on its own by providing information on why the infection cannot be resolved without treatment.
- With a particularly resistant or disinterested teen, ask them what he/she might tell a friend (you, in role-play) who was doing/not doing whatever it is that concerns you about your patient's behavior. This creates "cognitive dissonance," a discrepancy between where the patient is and where s/he wants to be, that the teen him/herself verbalizes by telling you, as the friend (like creating a third person), what you should and shouldn't be doing. It's the old "practice what you preach" technique!

Separate the teen's behavior from the person, and appeal to the strengths of the individual.

"You are such a bright person, why would you do such things that put you at risk?"

### **Additional resources**

For more information on how to provide effective behavioral counseling consider accessing any of the following organizations and/or materials:

New York State STD/HIV Prevention Training Center, Part II, Rochester, NY Phone: 716-530-4382

### **Publications**

Bright Futures, Guidelines for Health Supervision National Maternal and Child Health Clearinghouse 2070 Chain Bridge Road, Suite 450 Vienna, VA 22182-2536 Phone: (703) 821-8955 (703) 821-2098 fax http://www.brightfutures.org/

Guide to Clinical Preventive Services, 2nd Edition, Superintendent of Documents, U.S. Government Printing Office Phone: (202) 512-1800; the Stock No. is 017001005258 http://odphp.osophs.dhhs.gov/

The Guidelines for Adolescent Preventive Services Phone: (800) 621-8335. http://www.ama-assn.org/adolhlth/adolhlth.htm

### Relevant articles

- 1. Ajzen I: From intentions to actions: a theory of planned behavior, in Kuhland J, Beckman J (eds): *Action Control: From Cognition to Behavior*. New York, NY, Springer-Verlag; 1985:11-39.
- 2. Croft CA, Asmussen L: A developmental approach to sexuality education: implications for medical practice. *Journal of Adolescent Health* 1993;14:109-114.
- 3. Deci EL, Ryan RM: *Intrinsic motivation and self-determination in human behavior*, New York, Plenum Press; 1985.
- 4. DiFrancesco E. Getting teens to talk to you. Pediatric News, August 19, 1992.
- 5. Elster AB, Kuznets NJ (eds). AMA Guidelines for Adolescent Preventive Services (GAPS). Baltimore, Williams & Wilkins, 1994.
- 6. Goldenring JM & Cohen G. Getting into Adolescent Heads. *Contemporary Pediatrics* 5(7): 75-90. 1988.
- 7. Green M (ed). Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Arlington, VA: National Center for Education in Maternal and Child Health, 1994.

- 8. Hedberg VA, Klein JD, Jones AD: Health concerns of adolescents seen for preventive care: implications for health promotion. *Journal of Adolescent Health* 1996; 18(2): 153.
- 9. Klar H, Coleman WL: Brief solution-focused strategies for behavioral pediatrics. *Pediatric Clinics of North America* 1995; 42 (1): 131-142.
- 10. Knight JR, Goodman E, Pulerwitz T, DuRant RH. Reliability of the Problem Oriented Screening Instrument for Teenagers (POSIT) in an adolescent medical clinic population. *Substance Misuse* (in press).
- 11. Miller WR, Rollnick S. Motivational Interviewing. Guilford Press, New York, 1991.
- 12. Pratt HD, Greydanus DE: Social Learning Theory as a Basis for Office Counseling: A Tool for the Primary Care Physician of the 1990s. Adolescent Medicine State of the Art Reviews 1994; 5 (3): 451-464.
- 13. Prochaska JO, DiClemente CC. Transtheoretical therapy: toward a more integrative model of change. *Psychotherapy* 19: 276-88. 1982.
- 14. Prochaska JO, DiClemente CC: Stages of change in the modification of problem behaviors. *Progress in Behavior Modification* 1992; 28: 183-218.
- 15. Rollnick S, Heather N, Bell A. Negotiating behavior change in medical settings: the development of brief motivational interviewing. *J Ment Health*; 1: 25-37. 1992.

# Section Six: Chlamydia Screening and Treatment

To address the high incidence rate of chlamydia among teens, regular screening of sexually active teens and early treatment of infected teens and their partners is critical. This section of the Toolkit includes the following:

- Rationale for screening adolescents.
- Clinical manifestations and likelihood of complications.
- Diagnostic testing options.
- Facilitating the pelvic and genital exams.
- Managing treatment.
- Reporting to DPH.

# **Rationale for screening adolescents**

Adolescents have the highest risk for chlamydial infections and its most serious sequelae and they are among the least likely to use preventative care services. Accordingly, in Massachusetts, there is a serious and increasing problem with chlamydia infections among 15-19 year olds. In the year 2002, the rate among the 15 to 19-year-old age group was 879/100,000, almost five times the rate for all ages. <sup>67</sup>

Two thirds of primary care providers do not routinely screen adolescents for chlamydia, most erroneously believing that chlamydia is not a prevalent problem in their communities. Yet, research shows that behavioral and clinical predictors of infections (such as multiple partners, and prior STDs) failed to identify the females with the majority of infections. Since most chlamydial infections are asymptomatic and complications can be serious, broad-based screening is the cornerstone for preventing these complications and for controlling the spread of infections to newborns or sexual partners. Chlamydia screening is the **only** type of routine STD testing that the CDC uniformly recommends for asymptomatic individuals.

### Key clinical issue

The single criteria for screening should be whether or not the teen is sexually active. All sexually active teens should be screened annually for chlamydia.

### Why screen male adolescents?

Recent data has shown that the prevalence of asymptomatic infections in men is similar to that in women in many settings, making a compelling argument to screen males.<sup>71</sup> The availability of urine-based screening coupled with the ability to incorporate screenings into sports-related physicals or wellness visits presents a unique opportunity to screen partners of both sexes in an effort to reduce the pool of potentially infected sexual partners.<sup>72,73,74</sup>

<sup>66</sup> DL Wood et al., Access to Medical Care for Children and Adolescents in the United States, Pediatrics 1990; 86: 666-73.

<sup>&</sup>lt;sup>67</sup>Massachusetts Department of Public Health, Division of STD Prevention, 2000.

<sup>68</sup> Mitchel L. Zoler, Routine Chlamydia Tests Often Ignored, Pediatric News, June 2000.

<sup>&</sup>lt;sup>69</sup>Gale R. Burnstein et al., Incident Chlamydia Trachomatis Infections Among Inner-city Adolescent Females, JAMA, August 12, 1998, Vol 280, No. 6, 521-26.

<sup>&</sup>lt;sup>70</sup>Mitchel L. Zoler, Routine Chlamydia Tests Often Ignored.

<sup>&</sup>lt;sup>71</sup>United States Recommendations of the Advisory Committee for HIV and STD Prevention, HIV Prevention Through Early Detection and Treatment of Other STDs, MMWR July 31, 1998/47 (RR12); 1-24.

<sup>&</sup>lt;sup>72</sup>Ginocchio RH, Veenstrat DL, Connell FA, Marrazzo JM, *The Clinical and Economic Consequences of Screening Young Men for Genital Chlamydial Infections*, Sexually Transmitted Diseases, 2003:30:99-106..

<sup>&</sup>lt;sup>73</sup> M Nsuami et al, Screening for Sexually Transmitted Diseases During Preparticipation Sports Examination of High School Adolescents, Journal of Adolescent Health, 2003, May;32(5):336-339.

<sup>&</sup>lt;sup>74</sup> LY Wang et al, An Economic Evaluation of a School-Based Sexually Transmitted Disease Screening Program, Sexually Transmitted Disease, 2002, December;29(12):737-45.

# Clinical manifestations and likelihood of complications

### What are the clinical manifestations of chlamydia?75

- A full 75% of women and 50% of men with chlamydia are asymptomatic.
- Uncomplicated urogenital infections in women include bartholinitis, urethritis (urethral syndrome) and mucopurulent cervicitis.
- Uncomplicated urogenital infection in men is non-gonococcal urethritis.
- Other less frequent clinical manifestations in both men and women include conjunctivitis and proctitis.

### What is the likelihood of serious complications?76

- Up to 40% of women with untreated chlamydial infection will develop pelvic inflammatory disease (PID), which often presents with mild symptoms or which may be completely asymptomatic. Nonetheless, the severity of symptoms is unrelated to the degree of inflammation and tubal damage. Perihepatitis (Fitz-Hugh-Curtis Syndrome) can be associated with chlamydial PID.
- The occurrence of infertility increases with the number of episodes of PID, e.g., 8% after one episode, 20% after two and 40% after a third.
- Ectopic pregnancy occurs with an incidence of about 10% per PID episode.
- Epididymitis can occur in about 2% of untreated chlamydial infections in men. It has not been associated with infertility.
- Nearly 2/3 of neonates born to infected mothers will develop chlamydial colonization after delivery. Of these, 15% to 37% will develop conjunctivitis and 11% to 20% will develop pneumonia.

"There is general agreement that efforts to prevent pelvic inflammatory disease must address the earliest parts of the causal chain--that is, they must emphasize the primary prevention or early detection of infections of the lower genital tract.""

### Key clinical issue

Although not specific to adolescents, studies show that selective screening of women for chlamydial infection is associated with a 40% to 56% reduction in PID.<sup>78</sup>

### Offering reassurance

"Because most women and half of men who have the infection do not have symptoms, and the infection rates are highest in teenagers, we routinely screen all female and male teens."

<sup>&</sup>lt;sup>75</sup>STD/HIV Prevention Training Center of New England, Homestudy Module 2000 edition. <sup>76</sup>Ibid

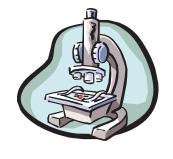
<sup>&</sup>lt;sup>77</sup>D. Scholes et al., Prevention of Pelvic Inflammatory Disease by Screening for Cervical Chlamydial Infection, NEJM 199; 334: 1362-6. <sup>78</sup>Ibid.

# **Diagnostic testing options**

There is a variety of testing options available to your practice. The primary differences in the testing options are as follows:

- Testing technology.
- Access to testing methodology.
- Specimen source.
- Sensitivity and specificity.
- Acceptability.

# Testing options for Chlamydia<sup>79</sup>



Test Name	Specimen Site	Sensitivity (True Positive)	Specificity (True Negative)	Comments
Culture	Cervix, pharynx, rectum, conjunctiva	50-90%	100%	Transport conditions are crucial; sensitivity is too low for urine. (<20%)

# **Antigen detection method**

Enzyme Immuno Assay (EIA)	Urethra, cervix, conjunctiva	40-60%	Up to 99%	Used less often as newer tests are more sensitive.
Direct Fluorescent Antibody (DFA)	Urethra, cervix rectum, conjunctiva	50-70%	>99%	Not used often as it is too time consuming to read and requires a fluorescent microscope.

### **Nucleic acid methods**

Non Amplified Nucleic Acid Hybridization Assay (DNA probe)	Urethra, cervix, conjunctiva	40-65%	98-99%	
Nucleic Acid Amplified Tests (NAAT)	Cervix, urethra, urine	>90%	>99%	Urine testing yields results similar to urethral and cervical specimens.

<sup>&</sup>lt;sup>79</sup>STD/HIV Prevention Training Center of New England, *Approach to Sexual History Taking and STD Screening*, 67.

No test is 100% sensitive and 100% specific. There is always a trade-off between sensitivity and specificity. Using the most sensitive and specific test available is the best way to detect the most true infections. Among teens, our main concern is failing to detect asymptomatic infections. The probability of having false positive tests should be kept in mind when using a test that is not 100% specific, particularly in low-prevalence populations. This can be minimized by using the most specific non-culture tests available, the NAATs.

### **Key clinical issue**

The NAAT tests require only the presence of one elementary body of chlamydia to test positive for chlamydia. As such, they are currently the most sensitive tests on the market.

### Preferred testing approach

- For women for whom a pelvic examination is indicated, the preferred test is an endocervical NAAT because of its high sensitivity and specificity. Use urine testing with a NAAT in the setting where a pelvic examination is not scheduled, acceptable, indicated, or routinely performed. If NAATS are not available, unamplified nucleic acid hybridization tests (DNA-probe), enzyme immunoassays (EIA) and direct fluorescent antibody tests (DFA) performed on an endocervical specimen are acceptable, albeit less sensitive, alternatives.
- For men, a urine-based NAAT is recommended, and preferred over a urethral sample (often unacceptable to males). If this is not available, a urethral sample (if acceptable to the patient) tested with a non-NAAT (DNA-probes, EIA, DFA) or culture is acceptable. A leukocyte esterase test (LET) on the first 10-15 cc of fresh unspun urine, followed by chlamydia testing if positive, is a less sensitive alternative.

The most common NAAT tests available are:

- Polymerase chain reaction (PCR) such as Amplicor ®
- Transcription mediated amplification (TMA) such as AMP-CT Aptima ®
- Strand displacement amplification (SDA) such as BDProbetec ®

Tips on collecting the urine specimen:80

- Make sure that the patient has not voided for at least 1 hours.
- Only the first 10-30 cc of urine should be collected
- Storage and transport instructions vary by test, so check the manufacturer's instructions.

<sup>80</sup>CDC:Screening Teststo detect Chlamydia trachomatis and Neisseria gonorraoeac infections-2002 MMWR 2002;51:20

### Cost and reimbursement issues

Although amplified DNA tests are more expensive than traditional non-culture tests, the time and expense savings associated with not having to perform an otherwise non-indicated pelvic exam and the decrease in morbidity from complications of chlamydia may outweigh the extra cost of the test.<sup>81</sup> While MassHealth reimburses for all types of chlamydia testing, this may not be true of other insurers. Although NAAT are preferred, they may not be available in some communities. We suggest that you check with your local laboratory provider regarding test availability and consider these factors when determining the best testing approach for your practice.

# Office system issues Which test is your office using? Is a change in testing methodology indicated? Does your laboratory provider perform NAAT testing?

<sup>81</sup> Charlotte A. Gaydos, Chlamydia Trachomatis Infections in Female Military Recruits, NEJM, Volume 339, Number 11, 739-44.



Key clinical issue

Screening for chlamydia should be done in the context of comprehensive care, which includes a complete sexual history.

### Female genital exams

"I wonder if failure to do genital exams on a routine basis is part of the reason girls grow up uncomfortable with medical care for their reproductive organs. We've sent them the wrong message when we skip part of their body. 82"

Genital examination for females includes examination of the breasts (including instructions on self-examination), abdomen, genitalia (including the vagina), cervix, ovaries and uterus. Part of the internal examination may include performing a Pap test.<sup>83</sup> If the teen is not sexually active, however, consider doing a genital examination and a pelvic examination only as needed.

Fear, embarrassment and worry that the physician will find something wrong are common feelings associated with the genital examination. These emotions may be especially heightened if this is the teen's first pelvic exam. Some suggestions for your practice to consider to make the experience more comfortable for the teen include:

- Offer the option to be screened by a female provider, if available. If a female provider is unavailable to perform the exam, allow the teen to have a female chaperone present during the exam.
- Begin by explaining the procedure and its importance, reinforcing what the teen does know and correcting any misinformation she has been given. Show her the instruments, and use illustrations if available. This should be done while the patient is dressed.
- Warm the speculum immediately prior to insertion and ask the teen to bear down as it is inserted.
- Remember to talk through each step of the process as its being conducted, e.g., "I am looking at your cervix and taking a swab of cells for the Pap smear, I am removing the speculum, I am feeling for your ovaries to see if they are of normal size." Offer reassurances to the teen on normal findings like "Your uterus is of normal size and shape."
- Ask for questions and input from the teen.
- Put funny, silly or culturally appropriate messages on the ceiling as a distraction.
- Place warmer mitts on the stirrups.
- Go slow and stop if the teen wants you to . . . remember, it is her body.

<sup>82</sup> American Academy of Pediatrics, ACQIP, 11.

<sup>83</sup>U.S. Preventive Services Task Force (USPSTF), Screening for Cervical Cancer, 2003. .

Some office practices may not be equipped to perform pelvic examinations and not all physicians are comfortable performing them. If these are practical realities within your office setting, it is critical for you to have a plan in place with a referring provider for ensuring that teens receive this care when needed. Remember that you can still screen for chlamydia (even though a pelvic cannot be performed) by using a urine test.

### Male genital exams<sup>84</sup>

Genital examinations for males involve examination of the penis and testicles, groin, perineal and other skin surfaces, rectal examination as needed, and instruction on testicular self-examination. Examination by a female physician may cause fear, feelings of inadequacy and potential discomfort. For this reason it may be helpful to offer the option of examination by a male provider, if available, or to suggest the use of a chaperone.

### **Chaperones**<sup>85</sup>

Examination fears for males and females can be reduced with the use of a chaperone. Chaperones are often appropriate when the physician is of the opposite sex or when the adolescent is more sensitive, emotionally unstable or anxious. The presence of a chaperone has been found to be comforting to the patient and could reduce any perceptions of inappropriate behavior on the part of the physician.

Depending on the preference of the physician or patient, chaperones may be used for the entire examination, or just the genital examination. Ask the teen whom he/she prefers to have as a chaperone, and whether he/she wants that person present for all or part of the examination. Recognizing that the use of a family member could either increase or decrease the teen's comfort level, it is a good idea to ask this question in private. That being said, common options for chaperones include the same-sex parent, same-sex sibling, same-sex friend or an office staff member.

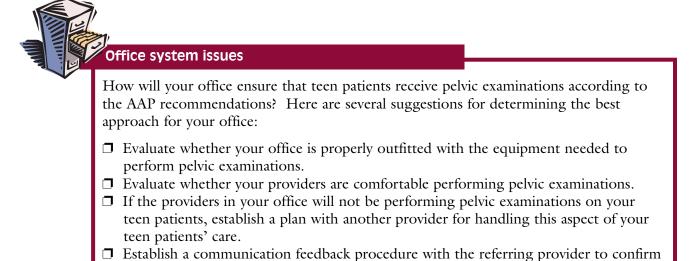
"Risk management has encouraged chaperones for pelvic exams and documentation in the chart of who is present." "80"

There are times when a teen may decline the use of a chaperone, usually due to concerns for privacy and/or confidentiality. Priority should be given to the teen's request and this request should be documented in the medical record.

<sup>84</sup> American Academy of Pediatrics, ACQIP, 9-10.

<sup>85</sup> Ibid., 8, 11.

<sup>86</sup>Ibid.



☐ If a patient asks for a same-sex provider, determine whether you can provide this.

that care was rendered and to receive clinical findings.

## Managing treatment

### **Notification of test results**

The first aspect of the treatment phase involves notifying the teen of the test results in a confidential manner once results are received from the reference lab. Refer to page 2–7 of this Toolkit for suggestions on how to make arrangements for follow-up communication at the time of the screening. If your office is unable to make contact with the teen for follow-up care, you may want to elicit the help of DPH staff by calling 617-983-6940. DPH will send staff out into the community to make a best effort to locate the teen.

Since notification may occur by phone and the teen may not return to the office for treatment, be prepared to make referrals for services that are appropriate for teens. This may include referrals to STD Clinics, Family Planning Clinics, State/Title X funded clinics, etc. Contact information for all referral resources is located in Section Eight of this Toolkit.

### **Treatment options**

There are two CDC recommended treatments for uncomplicated chlamydial infections. The first is azithromycin 1 gram orally in a single dose. This medication can be administered during the office visit (referred to as "observed" therapy, because the intake of medication is observed by the provider, thus insuring 100% compliance) or can be prescribed. The other recommended regimen is doxycycline 100 mg orally twice a day for seven days, but compliance with a seven-day regimen may be difficult for adolescents.

During pregnancy, the CDC -preferred choice of treatment is either erythromycin 500 mg orally four times a day for 7 days or amoxicillin 500 mg orally three times a day for 7 days. However, clinical experience and preliminary data suggest that azithromycin is safe and effective. This option is the preferred approach to treating pregnant teens.

### Key clinical issue

Since compliance with a seven-day therapy may be problematic for teens, the best treatment approach is to give a single dose of azithromycin, preferably observed.

### **Restrictions on sexual activity**

### **Key clinical issue**

Teens should be instructed to avoid sexual activity for seven days, <u>from the start of treatment</u> regardless of therapy (single dose or seven-day regimen). This time period allows for the infection to be fully cured and prevents the transmission of the infection to his or her sexual partner.

### Rescreening

Test of cure three weeks after completion of therapy is not recommended, except following treatment during pregnancy, anytime that therapeutic compliance is questioned, or if partner treatment cannot be established. However, the CDC recommends that all women with chlamydial infections be re-screened 3 to 4 months after treatment. This is especially important for adolescent women who are at highest risk of reinfection.<sup>87</sup>

### Charting

As with any other infectious disease, it important to document both the positive test results and the treatment in the teen's medical record. Refer to page 4–11 of this Toolkit for suggestions on options for handling documentation.

# **Reporting to DPH**

Clinicians are required to report cases of *Chlamydia trachomatis* (defined as a positive laboratory test) as well as other STDs. They must complete the information requested on the reporting cards. STD staff will never call a patient whose chlamydia case has been reported. If information is missing on the reporting cards (such as treatment), staff will call the provider to inquire about it. The reporting card is also a tool to communicate with the Division of STD Prevention.

Although laboratories are also required to report positive tests, demographic and clinical information is missing. These reports are merged with the clinician report. Reporting forms can be obtained from DPH by calling 617-983-6940. A sample reporting form is included in Section Nine of this Toolkit.

### Office system issues

Is your office compliant with DPH reporting requirements? In order to determine this there are several questions you and your staff can ask:

- ☐ Are all staff members who are involved in STD screening familiar with DPH reporting requirements?
- ☐ Do we have reporting forms readily available for use?
- ☐ Who within our practice will be responsible for completing the required forms?
- ☐ Do we have a mechanism for documenting that notification has been submitted?

<sup>87</sup> Centers for Disease Control and Prevention (CDC). Sexually transmitted diseases treatment guidelines 2002. MMWR 2002;51(No. RR-6):1-80.

# **Section Seven: Partner Management**

In order to prevent re-infection, it is critical that treatment of the partner(s) is always addressed when seeing a teen infected with an STD. However, partner notification is voluntary and patient confidentiality is protected by law. Therefore, the best approach is to try to convince the teen of the importance of partner evaluation and treatment. This section of the Toolkit offers suggestions on how to elicit the teen's cooperation, reviews options for partner notification and provides some suggested dialogue.



### What one survey of sexually experienced 15-17 year olds tell us:88

About talking with partners about STDs . . .

- 67% said that if they had a STD, they would be angry with the person who they got it from.
- 70% said that it is often more embarrassing to talk about sexual issues like STDs than to have sex.
- 52% said that if they found out that they had an STD they would feel VERY uncomfortable telling past sexual partners who may have been infected.

<sup>&</sup>lt;sup>88</sup>The Kaiser Family Foundation/MTV/TEEN PEOPLE, What Teens Know and Don't Know (but should) About Sexually Transmitted Diseases.

# Options for partner notification

### **Determining which partners to notify**

Any partners having sexual contact with the patient within 60 days preceding chlamydia diagnosis OR the most recent partner if >60 days since last sexual contact, should be notified, tested and treated.

### Assessing the risk of violence

It is important to acknowledge to the teen that problems of any kind can put a stress on even the best relationship. Ask him or her how he/she thinks his/her partner will react to the news. Specifically ask if he/she thinks the partner is likely to threaten or physically harm them. The safety of the infected teen is paramount. If there is reason to think that notification of the partner will result in harm to the teen, then the teen's safety should supercede concern over partner notification.

### **Notification options**

Partner notification can occur in any of the following ways:

- The teen may tell the partner him or herself.
- The teen may ask the physician to assist with notification.
- The teen may opt to utilize the DPH partner notification service.

In any of the above circumstances, notification by the teen or provider can occur either in writing or verbally in person or by phone. The key information to be relayed includes:88

- The nature of the exposure and risk of infection.
- The need for and location of appropriate clinical services.
- The need to avoid sexual contact until treated and or counseled.

### **Key clinical issue**

Partner management is an integral part of STD care. It is imperative that your office has a mechanism in place for ensuring that this aspect of care is addressed.

<sup>88</sup> Society for Health Advisers in Sexually Transmitted Diseases, Partner Notification Guidelines, UK, 1-8. http://www.shastd.org.uk/professional\_interest/partner.htm

### **DPH** partner notification

In discussing options for partner notification with the teen, it may be helpful to explain how the DPH partner notification service works. The tenets of DPH partner notification are as follows:<sup>89</sup>

- Partner notification is always voluntary.
- The STD interviewer does not need to know the name of the infected person. (However, if the partner has only one sexual partner, confidentiality may be compromised.)
- Notification is always face-to-face, in private with the identified partner(s).
- Partners are notified of possible exposure, not that they have been infected.
- The source of the information is never revealed.
- No records are kept on people who use the service; records are shredded after notification is performed.

The Regional Offices of DPH perform this function. There are six offices throughout the state. Refer to Section Eight of the Toolkit for information on how to contact the STD Regional Office nearest you.

### Legal issues

In Massachusetts, "all physicians owe their patients a duty, for violation of which the law provides a remedy, not to disclose without patient's consent medical information about the patient, except to meet a serious danger to the patient or to others. 90" It is not clear whether, under this rule, a physician may engage in STD partner notification without the infected person's consent. Physicians who do so may be putting themselves at legal risk. But providers should note that Mass. Gen. Laws ch. 111 s. 70F explicitly prohibits physicians, healthcare providers and healthcare facilities from "disclos[ing] the results of an (HIV antibody or antigen test) to any person other than the subject thereof without first obtaining the subject's written informed consent."

### Office system issues

- ☐ Has your office addressed all aspects of partner management?
- ☐ Are all staff persons who are involved in treatment familiar with partner notification options?
- ☐ How is partner notification or the patient's refusal to notify documented in the patient record?

<sup>&</sup>lt;sup>899</sup>Massachusetts Department of Public Health, Bureau of Communicable Disease Control, Division of STD Prevention, Partner Notification and Duty to Warn Separate and Not Equal, http://www.state.ma.us/dph/cdc/stdwar.htm, accessed 2/12/01

<sup>90</sup> Alberts v. Devine, 395 Mass. 59, 479, N.E. 2nd 113 (1985).

# **Obtaining cooperation**

In order to elicit the teen's cooperation in identifying and treating the partner consider the following:

- Educate the teen about transmission and the likelihood of re-infection if the partner does not receive treatment.
- Tell the teen that "the only way many people learn that they may have chlamydia is if a sexual partner has told them that they have been exposed. If people don't know they have the infection, he/she can develop serious health complications and spread the infection to future partners.
- Acknowledge the common feelings of anger, embarrassment and discomfort associated with learning that you have a STD and then being asked to disclose this information to partners. Express your empathy and support.
- Ask whether the partner(s) is symptomatic and whether the partner(s) has/have a physician.
- Ask whether he/she has discussed it already with the partner(s) and what decisions were reached.
- Offer to help them decide how to tell the partner(s). Discuss the options of doing this directly or anonymously.
- Offer to give the teen a prepared letter that he/she can give the partner(s) or instruct him/her on how to access DPH partner notification services.
- Ask the teen to recall any of the sexual partners, male or female, within 60 days prior to the diagnosis or the most recent partner if there has been no sexual contact within the 60 day time period.

A sample partner notification letter can be found on page 9–8 of this Toolkit.

"How would you like to let your partner(s) know that he/she needs to be tested and treated for Chlamydia? Would you like to tell him/her yourself or would you like me or another provider to get in touch with him/her? Some teens prefer to pass on this information in person or on the phone, while others prefer to use a letter, which I can help you to write. It's fine if you don't want him/her to know whom the letter is from. We (or the Department of Public Health) can also contact your partner without telling him/her that you are the reason that we are advising him/her to get treatment for an STD."

<sup>&</sup>lt;sup>91</sup>Massachusetts Department of Public Health, Bureau of Communicable Disease Control, Chlamydia Fact Sheet, 1-3. http://www.state.ma.us/dph/cdc/chlam.htm, accessed 2/12/01.

### Some possible dialogue for the teen to use with their partner:

- T: "We need to talk. You know how we have been having sex and not using a condom all the time, well, the doctor told me that I have a disease."
- P: "What do you mean a disease . . . I don't have anything."
- **T:** "It's called Chlamydia and it is curable. The only way you can get it is by having sex. So . . . you have to have it too . . ."
- P: "I don't have anything, and you're my only partner."
- T: "Even if you don't feel or see anything you need to get treated right away. But, we also need to talk about how we can prevent this from happening again . . ."

### Refusal to notify

The teen may need some time to process the situation before he/she is willing to proceed with partner notification. If the teen appears hesitant, tell him/her that you will give him/her some time to think it through and than will call or see him/her in the office to discuss it again within the next few days. Set up an agreed upon date/time for this follow-up discussion and send the teen home with information on how to access DPH partner notification service. Schedule another appointment in four weeks to retest the teen and continue the dialogue on prevention and partner notification.

# Treating the partner

Unless treatment is obtained for the partner, the teen is highly likely to become re-infected. Once the issue of notification has been resolved, review the various ways in which treatment can be obtained for the partner:

- Partner can see his/her own provider.
- Partner can be seen in your office.
- Partner can be referred to an STD clinic.

It may facilitate care if you provide the teen with a list of places where the partner can receive free or low-cost care. This resource list is located in Section Eight of this Toolkit.



### Office system issues

Has your office addressed all aspects of partner treatment? In order to determine this you and your staff can ask the following questions:

- ☐ Do we have an office policy on partner treatment?
- ☐ Are we willing to treat the partner without seeing him/her in the office?

# **Section Eight: Information and Referral Resources**

Because teens may not return for follow-up care, it is important to coordinate any necessary referrals for them as part of their visit. This section of the Toolkit includes referral resources for teens in many areas, including, but not limited to:

- Domestic violence.
- Family planning organizations.
- Free condoms.
- Free/low cost STD services.
- GBLT support.
- HIV screening/testing/education.
- Mental health and counseling centers.
- Peer education groups.
- Pregnancy and abortion counseling.
- Sexual abuse.
- Social service organizations.
- STD screening and treatment resources.
- Substance abuse.
- Teen parenting resources.



About what they want to know about referral resources . . .

- Is it a free service?
- How can you get it if you can't afford to pay it?
- I'll go by myself. Do I need an adult or parent's permission?
- How do I get it?
- Is it confidential? If they found something, would they only tell me?
- What will they talk to me about? Is it going to be straight information?
- Are there good doctors there to help you?



### **Office systems issues**

Is your office prepared to make referrals for teen patients? To help you determine this there are several questions that you and your staff can ask:

- ☐ Have we identified the conditions under which a referral is appropriate?
- ☐ Who within the office will be responsible for making referrals?
- ☐ Have we identified someone within the office to be responsible for updating/maintaining the referral listing?
- ☐ How often will we update the referral list?
- ☐ Do we have a mechanism to track the teen follow-through on referrals?

<sup>92</sup>PH, Teen Focus Group Results.

# General reproductive health/STD information

### Association of Reproductive Health Professionals (ARHP)

http://www/arhp.org/

Educates the public and health care professional about important reproductive health issues including contraception, sexually transmitted diseases, HIV/AIDS, sexuality, and infertility.

### CDC Division of Sexually Transmitted Diseases: Surveillance and Statistics

http://www.cdc.gov/nchstp/dstd/stats\_trends/stats\_and\_trends.htm Contains Surveillance reports and other statistics resources

### Centers for Disease Control and Prevention

http://www.cdc.gov/

Serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

• National Center for HIV, STD and TB Prevention. http://www.cdc.gov/nchstp/od/nchstp.html

### John Snow, Inc. (www.jsi.com)

Manages Regional Family Planning Training (Title X) Centers, providing education and prevention programs, provider training, etc.

### Planned Parenthood Federation of America, Inc.

http://www.plannedparenthood.org/index.html

Planned Parenthood Federation has affiliates that operate reproductive health centers offering family planning services, testing and treatment of sexually transmitted infections and sexuality education programs. Offers educational publications on all aspects of human and reproduction.

# Sexually Information and Education Council of the United States (SIECUS)

www.siecus.org

Develops, gathers, distributes information on sexuality, and promotes comprehensive sexuality education.

# "Taking a Sexual History: Increasing Effectiveness and Comfort in Prevention Counseling"

Continuing Education Video Course and Test for health Training

May 1,198 Length: 2 hours (videotape) available to borrow through their website library, www.famplan.org

### **National Resources**

### Hotlines

Ask-A-Nurse 1-800-544-2424 A 24-Hour, free, confidential healthcare hotline. Registered nurses listen carefully to your health-care questions and then help you make an informed decision about what to do. They will also work with you to find a doctor in your area or guide you to a wide range of community programs that provide such services as alcohol and drug abuse treatment, health education seminars, fitness activities and family counseling services. **CDC National AIDS Hotline** 1-800-342-AID Spanish: 1-800-344-SIDA 1-800-243-7889 TDD 1-800-227-8922 Childhelp USA 1-800-4-A-Child Child Abuse Hotline or 1-800-422-4453 D.S.S. 24-Hour Network for 1-800-799-SAFE Women's Safety 1-800-787-3224 TDD **Focus Adolescent Services** 1-877-362-8727 www.focusas.com or 1-877-FOCUSAS **National Domestic** 1-800-799-SAFE Violence/Abuse Hotline 1-800-787-3224 TDD Women's Safety National Gay and Lesbian Youth Hotline (Fri. & Sat. 7-10 P.M.) 1-800-347-TEEN 1-800-SUICIDE National Helpline Network 1-800-784-2433 National Runaway Switchboard 1-800-621-4000 1-800-621-0394 TDD Youth Crisis Hotline (17 and Under) 1-800-HIT-HOME

### **Massachusetts resources**

### AIDS/HIV

### **AIDS Action Committee**

Youth Only AIDS Line (YO Line) 1-800-788-1234 or TTY 617-450-1420

Western MA/Springfield: 1-413-737-2712

AIDS Action Hotline 1-800-235-2331

DPH - HIV/AIDS Bureau (free condoms) 1-617-624-5300

250 Washington St., 3rd Floor Boston, MA 02108

Massachusetts Department of Public Health Division of Sexually Transmitted Disease Control 1-617-983-6940

Mayor's Healthline 1-617-534-5050

Teens and AIDS - Department of Public Health

**HIV** information line – 617-624-5300

Provides information on HIV counseling and testing locations.

Latino Health Hotline (linea Informa de Salud) 1-800-637-3776

Statewide bilingual hotline that provides referrals and information on AIDS and safe sex, as well as other health problems. The Latino Health Hotline is open Monday - Friday from 9:00 am to 5:00pm.

# **Eating Disorders**

**Eating Disorders Clinic** 1-617-355-7178

Children's Hospital 300 Longwood Avenue Boston, MA

Massachusetts Eating Disorder Association 1-617-558-1881

www.focusas.com

Massachusetts Eating Disorder Association

92 Pearl St., Newton, MA 1-617-558-1881 meda@medainc.org

Offers information, referrals and support groups for adolescents with eating disorders and for parents of children with eating disorders.

with all food addictions including anorexia, bulimia

Overeaters Anonymous

and compulsive overeating.

www.overeatersanonymous.org Self-help group for food addicts that uses a 12-step fellowship based on Alcoholics Anonymous. Deals

## **Gay and Lesbian Services**

Boston Gay and Lesbian Adolescent Social Services	1-617-266-3349
(Boston GLASS)	

Adolescent center that provides services to gay, lesbian, bisexual and transgender, and youth questioning their sexuality who are ages 13-25.

Gay and Lesbian Helpline 1-617-267-9001

## **Health Services Information**

www.maclearinghouse.com

Massachusetts Health Promotion Clearinghouse 1-800	0-952-6637
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## **Hospitals**

Baystate Health System - Family Advocacy and Teen Clinic	413-784-9816
Springfield, MA	or 413-794-0555

#### **Boston Medical Center**

818 Harrison Avenue

Boston, MA

Provides anonymous HIV testing, free condoms, counseling and referrals. Project Trust also has on-site primary care available for people infected with HIV who have no insurance

people infected with HIV who have no insurance.	1-617-414-4086
Adolescent Center	1-617-534-4086
Children's Center	1-617-534-5946

#### Children's Hospital

300 Longwood Avenue, Boston AIDS/HIV Youth Services

Boston Happens Program 1-617-355-8496

Provides HIV services and support to HIV-infected, homeless, at-risk adolescents and young adults aged 13-24 in the Boston Area.

# Massachusetts League of Health Centers 1-617-426-2225 or 1-800-475-8455

## **Pregnancy and Parenting**

Alliance for Young Families 1-617-482-9122 **Healthy Start** 1-800-531-MOMS 1-800-531-6667 Massachusetts Parents Anonymous 1-617-267-8077 Teen Parent Support Group Parental Stress Line 1-800-632-8188

## **Substance Abuse**

Alateen	1-617-843-5300
Alcoholics Anonymous	1-617-426-9444
Alcohol and Drug Abuse Hotline	1-800-327-5050
Bridge Over Troubled Waters	1-617-423-9575
Children from Alcoholic Families Group	1-617-623-2079
Drug Help Referral Hotline (US Dept of Health)	1-800-662-HELP 1-800-662-4357
Massachusetts Inhalant Abuse Task Force - IDPR Group Support Services www.state.ma.us/dph/inhalant	1-617-437-8493 1-617-623-2080
Massachusetts Poison Control Center	1-617-232-2120 1-800-682-9211
Massachusetts Smoker's Quitline www.trytostop.org Spanish:	1-800-879-8678 1-800-833-1477 TTY 1-800-833-1477
Massachusetts Smoker's Quitline Tip Line (English and Spanish)	1-800-943-8284
Massachusetts Substance Abuse Helpline	1-800-327-5050
Smoking Cessation Information	1-800-422-6237

## **School-Based Health Centers**

There have been many changes in the number of DPH-funded school based health centers. The list below represents those schools for which DPH covers chlamydia testing as of December, 2003. For up to date information on participating schools, contact:

Bureau of Family and Community Health 250 Washington Street, Boston, MA 02108 Renée Aird, B.S.N, M.S. Director, School Based Health Center Program Tel. (617) 624-6015 Fax. (617) 624-6062

#### **Boston Latin Academy**

Maria Garcia-Aaronson, Headmaster - (grades 7-12) 205 Townsend Street, Boston 02121, (617) 635-9957 e-mail address: academy@boston.k12.ma.us

#### **Brighton High School**

Charles Skidmore, Headmaster (on-site health center) 25 Warren Street, Brighton 02135, (617) 635-9873 e-mail address: brighton@boston.kl2.ma.us

#### **Burke High School**

Carol Moore, Headmaster (on-site health center) 60 Washington Street, Dorchester 02121, (617) 635-9837 e-mail address: burke@boston.k12.ma.us

#### Charlestown High School

Micheal Fung, Headmaster 240 Medford Street, Charlestown 02129, (617) 635-9914 e-mail address: charlestown@boston.kl2.ma.us

#### **English High School**

Jose Duarte, Headmaster (on-site community center 617-635-5244) 144 McBride Street, Jamica Plain 02130, (617) 635-8979 e-mail address: english@boston.k12.ma.us

#### Madison Park Technical Vocational High School

Charles McAfee, Headmaster/Director 55 Macolm X Blvd/New Dudley Street, Roxbury 02119, (617) 635-8970 / 635-9802 e-mail address: madison@boston.kl2.ma.us

#### O'Bryant High School

Jose Vidot, Headmaster 55 New Dudley Street, Roxbury 02119, (617) 635-9932 e-mail address: obryant@boston.k12.ma.us

#### Snowden High School

Gloria Coulter, Headmaster - (on-site health center) 150 Newbury Street, Boston 02116, (617) 625-9989 e-mail address: snowden@boston.kl2.ma.us

## **Massachusetts Prevention Centers**

Boston Regional Center for Healthy Communities 617-451-0049

617-451-0007 TTY

Southeast Upper Regional Center for 508-583-2350

Healthy Communities 508-583-2847 TTY

(Brockton)

e-mail: mpcmets@ma.ultranet.com

Metrowest East Regional Center 617-441-0700 for Healthy Communities 1-888-272-5155

(Cambridge)

e-mail: www.preventioncenter.org/

Greater Western Massachusetts Regional 413-584-3880 Center for Healthy Communities 1-800-850-3880

e-mail: www.state.ma.us/dph/mpc 413-586-6598 TTY

## **STD Clinic Schedule**

Clinic Name	Monday	Tuesday	Wednesday	Thursday	Friday
BOSTON					
Boston Medical Ctr. 617-414-4081	8-11am 1-3 pm	8-11am 1-3 pm	1-3 pm 5-6 pm	1-3 pm	8-11am
Mass General GID Clinic 617-726-2748	8:30-11am 1-3 pm 5-7 pm (evening Clinic	8:30-11am	8:30-11am 1-3 pm	8:30-11am	9-11 am
Chelsea Health Ctr. 617-887-4600 NORTHEAST	by appointment only)	1:30-3:30 pm CHELSEA		3-6 pm CHELSEA	
LOWELL Lowell Community Health Ctr. 978-937-9700		3-6:30 pm		1-4 pm	
BROCTON Brockton Hospital 508-584-1200	4:30-6:15 pm		8 am-12 pm	4:30-6:15 pm	
FALL RIVER STAR Family Healthcare Ctr. 508-679-5222, ext. 3228		10 am-5 pm	10 am-5 pm	9 am-5 pm	
CENTRAL					
WORCESTER Planned Parenthood 508-854-3300	3:30-6 pm		3:30-6 pm		
WEST PITTSFIELD Berkshire Medical Ctr. 413-447-2654	9 am-4:30 pm	9 am-4:30 pm	9 am-4:30 pm STD/TB/HIV/ATS	9 am-4:30 pm	9 am-4:30 pm
SPRINGFIELD Brightwood Health Ctr. 413-794-8354			Mason Square NHC 9 am-12 noon	Brightwood Health Center 2-5 pm	

### ALL CLINICS ARE WALK-IN UNLESS OTHERWISE NOTED.

This schedule is subject to change. Check the DPH website for up to date information at www.state.ma.us/dph/cdc/std/services/clinicsched.htm

## **Section Nine: Tools**

This section of the Toolkit offers several tools that you can use or modify to help implement your chlamydia clinical improvement and education program. You may already be using some tools like these in your office. If you have similar systems in place, then skip this section unless you feel that there is a need to improve or expand your efforts.

### Here's what you'll find:

- Quick reference guide
- Sample patient contact form
- Sample confidentiality policy
- Notice of confidentiality
- Minor's access to confidential reproductive health care in Massachusetts: A practitioner's resource
- Sample partner notification letter
- Risk factor checklist for Chlamydia & other STD's
- Sexuality and sexual behavior anticipatory guidance checklist
- Sample history and physical forms
- DPH notification form

Chlamydia Quick Reference Guide for Providers Serving Sexually Active Adolescents and Their Partners

Type of intervention	Recommendation	Rationale
Chlamydia Screening	Sexually active women age 25 years and under	<ul> <li>Incidence and prevalence are greatest</li> </ul>
	<ul> <li>Screen women at least once a year</li> </ul>	among adolescents
	• If pregnant, screen 1st and 3rd trimester	<ul> <li>75% of women are asymptomatic</li> </ul>
		Women are at substantially increased
		risk for PID and sequelae
		<ul> <li>Untreated infections in pregnant women</li> </ul>
		can be transmitted to newborns
		<ul> <li>Screening has been shown to reduce the</li> </ul>
		incidence of PID and to be cost-
		effective
	Sexually active men aged 25 years and under	<ul> <li>50% of men are asymptomatic and</li> </ul>
	<ul> <li>Consider screening men once a year</li> </ul>	represent a significant reservoir of
		ıntection
	Sexually active women over the age of 25 years	Risk factors include:
	<ul> <li>Screen women once a year if at risk</li> </ul>	Not using condoms correctly or consistently,
	• If pregnant, screen 1 <sup>st</sup> and 3 <sup>rd</sup> trimester if at risk	new or multiple sex partners in the last three
		months, new or multiple sex partners since the
	Sexually active men aged 25 years and under	last test, infected with another STD, prior
	<ul> <li>Consider screening for chlamydia once a year if at risk</li> </ul>	history of STD.
: :	,	
Diagnostic Testing	Female	
	<ul> <li>If pelvic exam indicated do endocervical NAAT</li> </ul>	Highest sensitivity and specificity with
	• Use urine based NAAT if no pelvic exam	endocervical NAAT, followed by urine NAAT
	Secondary choices are DNA probe, EIA or DFA on endocervical	
	specimen	
	Male	
	<ul> <li>Urine based NAAT is first choice</li> </ul>	Urethral sampling often not acceptable to males
	<ul> <li>Urethral sample with a culture or non-NAAT test (DNA probe,</li> </ul>	
	EIA or DFA)	
	<ul> <li>Last choice is LET on unspun urine followed by chlamydia</li> </ul>	
	testing if positive	

Type of intervention	Recommendation	Rationale
Patient Treatment	<ul> <li>Not pregnant</li> <li>Azithromycin 1 gram orally once in a single dose is preferred</li> <li>Doxycycline 100 mg orally twice a day for seven days is second choice</li> </ul>	Compliance with seven day regimen may be difficult for adolescents
	<ul> <li>Pregnant</li> <li>Erythromycin base 500 mg orally four times a day for seven days</li> <li>Amoxicillin 500 mg orally three times a day for seven days</li> <li>Azithromycin 1 gram orally once in a single dose</li> </ul>	Azithromycin is not recommended as first line by CDC as there is not yet enough data on safety and efficacy. However, clinical experience and preliminary data suggest that azithromycin is safe and effective and is the preferred option for adolescents.
	All patients  • Abstain from intercourse for seven days from start of any treatment	Allows infection to be fully cured and transmission to partner avoided.
Partner Treatment	Any partners having sexual contact with the patient within 60 days preceding chlamydia diagnosis OR the most recent partner if >60 days should be <b>tested and treated</b>	In the absence of partner treatment, reinfection is likely
Rescreening	Pregnant  • 3-4 weeks after therapy	Compliance may be an issue and azithromycin has not been well studied.
	Not pregnant  • 3-4 months or earlier if partner treatment can not be confirmed	Patients with a history of prior chlamydial infection are at highest risk of reinfection
Prevention	Primary prevention is abstinence     If sexually active:	
	judgment and cause you to take risk	

# Sample patient contact form

Patient	Birth Date
Address	
	ach you to coordinate your medical care. Check all tha
apply. Today's date is	_
By mail	
☐ At the address above	
☐ At this address	
By phone (List Number)	
☐ Home phone	
☐ Cell phone	_
☐ Beeper	
☐ School Clinic	
May we identify ourselves when we ca	all?
☐ Yes	
□ No	
	alled so that you know to call us back?
Does it matter whether a male or fem	ale office assistant makes the call?
☐ Yes, female assistants only	
☐ Yes, male assistants only	
☐ No, it doesn't matter	
	es to reach you?
Is it acceptable to leave a voice mail r	nessages?
□ Yes	
□ No	
If we are unable to reach you according call who will help us to reach you?	ng to the plan above, is there someone else we can
☐ Yes (please provide name, relati	onship and phone number on the line below)
□ No	
☐ Other	
optimal contact, please describe below	ld like for us to know or do in order to establish v.
If you need to reach us	
Your doctor's name is Sharon Healer.	
☐ Call 508-123-4567 during office	ce hours (Monday through Friday, 8am to 4:30 pm)
☐ Call 508-123-7890 on weeken	ds or after regular office hours
Our office address is:	

Teen Medical Care Inc., 32 Holistic Way, Healthytown, MA 00007

## Sample confidentiality policy

## **Regarding Adolescent Healthcare**

Adolescence is a time of rapid physical and psychological change, complicated by ever-present peer pressure. Providing excellent health care to adolescents requires a sensitive and thoughtful approach. Parents are encouraged to accompany their adolescents for health-care visits and remain active and involved in their healthcare. However, parents must recognize that adolescents need to take increasingly greater responsibility for their healthcare and that their doctor or nurse may request an opportunity to spend some time with the adolescent alone.

As the adolescent begins to take responsibility for his/her own health care, he/she will be accountable for:

- Being aware of his or her own health needs.
- Talking openly with the healthcare provider about issues of concern.
- Following the treatment plan agreed upon.
- Keeping appointments.

There are some situations where state law allows adolescents to consent for care, and in these cases the records from those services will be kept confidential from parents unless safety issues are involved. For example, teens that have or suspect they have a sexually transmitted disease (STD) may consent to diagnosis and treatment for that STD. In these cases, the medical records documenting these services are confidential. However, there are situations when, in the judgment of our professional staff, an adolescent's life or well-being would be jeopardized without family involvement.

Parents with questions or concerns about this policy are encouraged to share their concerns with their adolescent's doctor or nurse practitioner.

I have read this policy statement and discussed any concerns with my adolescent's doctor or nurse practitioner.

Parent's name	
Adolescent's name _	
Date	

## **Notice of confidentiality**

#### THIS A SAMPLE FORM ONLY AND DOES NOT CONSTITUTE LEGAL ADVICE

Please be advised that on	, the services listed below were provided
	[date]
to	, a minor, born on,
[patient's name]	[patient's birth date]
	, confidentially. These services were
[fill in insurance I.D. numbers a	as appropriate]
lawfully provided without a paren	nt's consent.
All services provided purs services.	uant to this visit, including laboratory and pharmaceutical
Specified services (please	describe below)
the above listed services to the	t that disclosure of health care information related to patient's parent or guardian without the patient's by to the best interest of the patient.
Signature:	Date:
On behalf of:	Title

Developed by the American Civil Liberties Union (ACLU), www.aclu.org, Guide to Protecting Teen's Confidentiality Under Federal Medical Privacy Regulations.

# Minors access to confidential reproductive health care in Massachusetts: A practitioners resource

This resource was developed by Physicians for reproductive Choice and Health. Copies can be obtained by contacting the organization by phone at 646-366-1890 x11 or by visiting the website at www.prch.org

## Sample partner notification letter

Date:
Dear
Someone you had sex with has been diagnosed with a sexually transmitted infection called Chlamydia (kla-mid-ee-ya). It is very important that you go to your medical provider as soon as possible. You need to tell your provider about your sexual contact and ask for treatment. Your provider may also test you for chlamydia and may need to examine you.
If not treated, Chlamydia is an infection that can cause serious complications in women, such as an infection of the reproductive organs called pelvic inflammatory disease or PID, which can leave women unable to have babies. In men, the infection can cause discharge (drainage) from the penis and burning when urinating and may damage parts of the testicle. But chlamydia can be easily treated with an antibiotic (medicine) that your provider can give you. It is very important that you take all of your medication.
If you do not get treated, you may become sick. You also may spread the disease to other people you have sex with. It is also very important that you tell all sexual partners you have had in the past two months to get antibiotic treatment. You should not have sex with anyone until seven days after you have finished taking your medicine. The reason for this is because if your current or past partners don't get treatment they can reinfect you or they can infect other people whom they have sex with.
Sexual contact may put you at risk for other sexually transmitted diseases. Please ask your medical provider for more information or to answer any questions you have about any of the information in this letter. If you do not have a medical provider, please read the list on the back of this letter for some clinics that will treat you confidentially and free-of-charge.
Sincerely,

[Add a listing of local clinics/provider sites that will provide treatment free of charge.

Resource Information is in Section Eight of this Toolkit]

## Risk factor checklist for chlamydia and other STDs

	Risk factors for STDs	Strategies for preventing STDs
	Anyone who has had sex even once is at risk for an STD. Behaviors that increase risk are:	The best way to prevent STDs is not to have sex, including vaginal, oral or anal sex. If you are having sex, there are things you can do to reduce your risk.
	Ever having sex without using a condom (or dental dam).	Always use a latex condom for vaginal, oral and anal sex. Use a water-based lubricant for vaginal and anal sex. Use a dental dam for oral sex with females and oral-anal sex.
	Having more than one sexual partner ever.	Limit your partners. The more sex partners you have, the greater the risk.
	Having a partner who has other sex partners or has had multiple sex partners in the past.	Talk to your partner about other sex partners past and present and about past STDs.
$\Box$	Having a partner who has symptoms of STDs.	Know the signs and symptoms of STDs.
	Drinking alcohol or using drugs.	Don't have sex when you're drunk or high. Alcohol and other drugs can make it harder to use a condom correctly.
	Having shared needles to inject drugs or steroids, or had sex with someone who has.	Talk to your partner about drug use, including needle use.

Have regular screenings for Chlamydia and other STDs if you are having sex.

Remember that many people, both male and female, don't have symptoms.

Talking honestly with your doctor or nurse about your risk factors will help you get better health care.

# Sexuality and Sexual Behavior Anticipatory Guidance Checklist 95

Normal sexual feelings
Sexual preference
Gay/Lesbian issues
Different kinds of sex
Interest in having sex
How to say no
Abstinence
Sexual abuse
Birth control options
Birth control access
STDs
☐ Most common
☐ Sign and symptoms
STD risk factors
☐ Sex without condoms
☐ Alcohol/drug use
☐ Multiple partners
☐ Partners with STD symptoms
STD prevention
☐ Safe sex
☐ Correct condom use
☐ Limit sex partners
Need for pelvic/Pap smear
Need for breast self-exam
Need for testicular self-exam

<sup>93</sup> Excerpts from Bright Futures anticipatory guidance checklists.

## Sample history and physical forms

## Guidelines for Adolescent Preventive Services (GAPS) questionaires

English Middle-older Adolescent Questionaire http://www.ama-assn.org/ama/upload/mm/39/periodic.pdf

Spanish Middle-order Adolescent Questionaire http://www.ama-assn.org/ama/upload/mm/39/midspanish.pdf

## Bright Future Encounter forms For adolescent visits

6 years - 21 years English http://www.brightfutures.org/encounter/provider/pdf/pro\_6yr\_21yr.pdf

6 years - 21 years Spanish http://www.brightfutures.org/spanish/encounter/prof/menu\_pspan.htm

Suggestions for Taking a Sexual History for Teenage Girls
The Centers for Disease Control and Prevention recommends screening all sexually active teenage girls for chlamydia each year. We encourage you to place this sheet in the medical record of the above-named patient and use it to guide a discussion about sexual activity and sexually transmitted diseases (STDs) at her next visit.
Ask about menstrual history first, and then follow with sexual history:
☐ What have you learned in school or elsewhere about STDs and birth control?
☐ Do you date? How old is he or she? How does he or she treat you?
☐ Are you having or have you ever had sex, including oral sex?
If your patient tells you she has not had sex:
"I would like to make sure that I understand your answer. People have sex in many different ways. By sexual activity, I mean to ask if you are having any oral, vaginal or anal sex."
☐ Have you thought about what you might do if you ever felt pressure to have sex?
☐ Are you thinking about having sex with anyone in particular?
"I am always available to discuss your questions and concerns."
If your patient tells you she <u>has</u> had sex:
☐ When was the last time you had sex?
☐ Do you have sex with girls, boys or both?
☐ What kind of sex? Vaginal? Oral? Anal?
☐ Are you using a method to prevent pregnancy? Have you ever been pregnant?
"I would like to ask you some questions about risky behavior, because there may be information I can offer you that will help you reduce your risk of illness or injury."
☐ Do you and your partners use condoms? Never? Sometimes? Always?
☐ Do you ever have unprotected sex? Does your partner?
☐ Have you ever had sex under the influence of drugs and alcohol?
☐ Have you ever had an STD?
☐ Has anyone ever touched you in a way you didn't like or forced you to have sex?
Notes:
DateSignature

Please place this in the medical record of\_\_\_\_\_

## Creating an Environment Conducive to Sexual History Taking ☐ Make sure that you have an opportunity to speak with a teenager without her parent. Make this a standard part of the office visit and explain it up front to the parent and teen. Reinforce confidentiality within limits. In Massachusetts, New Hampshire and Maine, state law permits providers to diagnose and treat STDs without parental consent. ☐ Introduce sensitive topics by starting with non-threatening topics first and moving to more sensitive issues. The American Academy of Pediatrics (AAP) recommends HEADS, which stands for Home, Education, Activities, Drugs and Sex. ☐ All adolescents should be asked at least annually about involvement in sexual behaviors that may result in: unintended pregnancy • chlamydia or other STDs HIV infection Ask questions and offer explanations about sexuality in a straightforward manner. Avoid euphemisms. Offer guidance annually on responsible sexual behaviors, including latex condoms to reduce the risk of STDs and HIV as well as other forms of birth control. ☐ Screen for tobacco, alcohol and drug use as well as other risky behaviors, such as weapons and eating

## **Key Clinical Issues:**

disorders or obesity.

Alcohol and drug use play a central role in the sexual activity of many adolescents, placing them at higher risk of engaging in unprotected sex and getting STDs.

Because older males tend to have or have had multiple sexual partners, girls who have older male sexual partners are at higher risk for chlamydia infections and other STDs.

Anal intercourse may be used by some heterosexual teens as a way to preserve virginity and protect against pregnancy.

Excerpted from The Chlamydia Toolkit for Clinicians, Massachusetts Division of Medical Assistance, June 2001.

For more information, refer to:

Mass. Department of Public Health, STD/HIV Prevention Training Center.

AMA, Guidelines for Adolescent Preventive Services, 1997.





## **DPH notification form**

## **Section Ten: Patient Education Materials**

This section of the Toolkit includes sample patient educational materials to assist you in your efforts to implement the clinical recommendations. Some of these materials have been developed by DMA specifically for this project and others are from sources such as DPH and CDC. The following educational materials are included:

- Saying "NO" is easier than you think
- When condoms aren't "cool"
- Check it out: How your doctor or nurse practitioner helps you stay healthy
- Chlamydia: Get the Facts
- Chlamydia Reduce your risk (Spanish)
- STD Fact Sheet: Chlamydia
- Questions and answers about your first pelvic exam
- Multilingual STD education resources
- Websites for teens

Additional information and materials are available at the Massachusetts Department of Public Health STD Clinic Website at http://www.state.ma.us/dph/cdc/std/divstd.htm



# What some teens tell us: 94

#### About what they prefer . . .

Easy, uncomplicated ways of accessing information like through group discussions, the Internet, or graphically illustrated print materials or video programs.

<sup>94</sup>MDPH, Teen Focus Group Results.

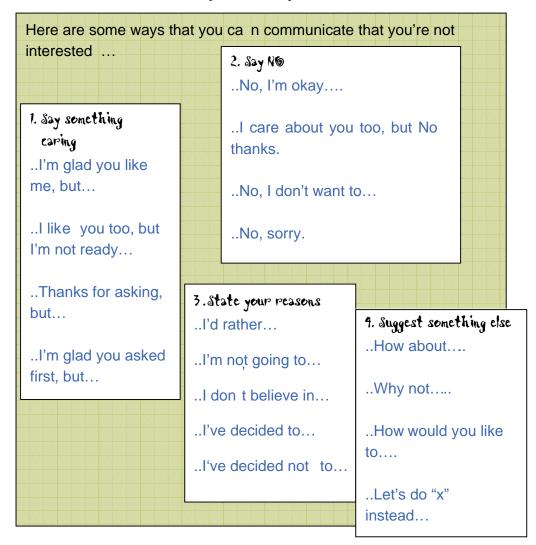
# Saying NO...it's easier than you think!

Sometimes a partner will try to pressure you into doing do something that you really aren't comfortable with or ready for, like having sex. Here are some ways that you can back up and get them to back off.

Remember, It's your body!

Example: Brendan and Jesse are both 17 and have been school friends for years.
They are at a party where they have been drinking. Brendan is feeling sexually aroused and wants to have sex with Jesse. She is not interested, and responds to Brendan's advances:

"I know we've been friends for a long time and I really like you, but I don't want to sleep with you... I don't like you in that way... I think we would spoil our friendship if we went to bed...I'd better get going anyway. Things are getting little too heavy here and I'm uncomfortable."



they, you don't even that to give a reason. You don't need to argue. If it doesn't feel comfortable, respect your GWN feelings, and just leave.

I'm on the pill. We don't need a condom. Let's use it anyway. We'll both be protected from infections we may not know we have.

# WHEN CONDOMS AREN'T "COOL"...

HOW TO TALK TO YOUR PARTNER AND PROTECT YOU BOTH FROM INFECTION.

Condoms are so fake! They turn me off.

An infection isn't so great either. Let's try it. Or maybe we can try

Just this once.

Once is all it takes.

Well, I don't have a condom with me.

I do.

I'm not. This way we'll both be protected.

I won't have sex if you're going to use a condom.

So, let's put it off until we can agree or try some other things besides

I'm a virgin

I can't feel a thing when I'm wearing a condom. It's like wearing a raincoat in the shower.

You'll still feel enough! Let's just try it.

By the time you put that on, I won't be in the mood.

If we really feel for each other, we should be able to stay in the mood. I love you! Would I give you an infection?

You wouldn't mean to, but you can have one without knowing it. So could I. Better safe than sorry for both of us.



# GHEGK ID OUD!

How your Doctor or Nurse Practitioner helps you stay Healthy

# Why do they ask about such personal stuff?

Asking questions is an important way, in addition to the physical exam, that your health care provider finds out about your health now and any health risks you may be taking that could affect you later.

Just like questions about diet and exercise, it is routine to ask all teens and adults about whether they smoke, drink, use other drugs, or are sexually active.

# It's embarrassing to talk about...

(...BUT, the more open and honest you are, the better your chances of staying healthy!)

Doctors and nurse practitioners want you to know that some personal behaviors or activities are really risky to your health – like having unprotected sex.

Asking you about your sexual activity helps them to know if you are at risk for sexually transmitted diseases. Based on what you tell them, they can then examine and treat you properly.

# This is my private business. Who are they going to tell?

Well, you need to know that your health professional is <u>required by law</u> to keep most stuff confidential, but if you are worried, ask about if or **how** what you tell them will be kept confidential.



You can always ask to be alone to speak with your doctor or nurse practitioner about your personal life, if you don't want anyone else (like a parent) to hear what you are talking about.

# I'm not comfortable with the physical exam.

If you are nervous about being alone with your doctor or nurse practitioner during the physical, you can always ask for a nurse, friend or family member to stay with you during the visit.

# **Chlamydia: Get the Facts**

For additional copies of this brochure contact:

Journeyworks Publishing P.O. Box 8466 Santa Cruz, CA 95061 1-800-775-1998

Title#5118

# Chlamydia Fact Sheet

# What is Chlamydia?

Chlamydia (pronounced: clam-id-ia) is the most common sexually transmitted disease (STD) in the United States today. It is caused by bacteria that are transmitted during sexual intercourse. You can have chlamydia without even knowing it. If it is not treated, chlamydia can cause a painful infection that can leave you unable to become pregnant when you get older. Girls and women who are infected with chlamydia are more likely to become infected with HIV/AIDS. The risks to boys and men include painful infections.

# But why should I be worried about chlamydia?

Three million Americans become infected with chlamydia each year and most of them are girls and women under 25 years old. *As many as one in ten teenage girls who is tested for chlamydia is infected.* 

# How do I know if I have chlamydia?

Usually, chlamydia has no symptoms. In fact, 3 out of 4 girls and women with chlamydia have no noticeable symptoms. When symptoms do occur in girls or women, they include: vaginal discharge or itching, abdominal pain or bleeding between menstrual periods, and nausea and fever. Many women and men find out they have chlamydia **only** if their sexual partners tell them that they have been exposed or if they are tested for it.

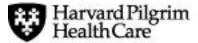
The only sure way to know if you have chlamydia is to be tested for it in a doctor's office or medical clinic. Talk to your health care provider about whether or not you should be tested, especially if you are sexually active. The test is quick and simple, much like a Pap test. Any test results will be shared only with you; they are completely confidential.

If you think that you may be at risk, get tested.

It's the only way to be sure.

# How is chlamydia treated?

Chlamydia is treated with antibiotics. Your health care provider will determine the best treatment for you. If you and your partner are both infected, you should be treated at the same time.





# How can I avoid getting chlamydia?

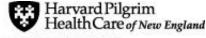
- Not having sex is the only sure way to prevent chlamydia.
- Use a condom *every time* you have sex.
- Limit your sexual partners and ask your partner to do the same. Your risk of getting any sexually transmitted disease increases with the number of sexual partners you and your partner have.

# How can people with chlamydia avoid spreading it?

- Avoid having sex while you are being treated.
- Tell your sexual partners about your infection. Be sure that they get tested.
- Use a condom every time you have sex.

# How can I get more information?

- Ask your doctor or health care provider.
- Visit the Harvard Pilgrim Web site: www.harvardpilgrim.org
- Call the National STD and AIDS hotline: 1-800-342-2437 and 1-800-227-8922.
- Visit the Massachusetts Department of Public Health web site: www.state.ma.us/dph/cdc/factsheets/chlam.htm



# **Chlamydia - Reduce Your Risk (Spanish)**

For additional copies of this brochure contact:

Channing L. Bete Co., Inc. 200 State Road South Deerfield, MA 01373 1-800-628-7733

Item #31656C-09-99

# Sexually Transmitted Disease (STD) Fact Sheet Chlamydia

Chlamydia (cla-MID-ee-ah) is a **S**exually **T**ransmitted **D**isease (STD) caused by a type of bacteria called *Chlamydia trachomatis*. Chlamydia can infect men, women and newborns. Chlamydia is the most common bacterial STD in the United States.

## How is chlamydia spread?

Chlamydia is passed from one person to another during vaginal and anal sex. It may also be spread to the throat through oral sex. Newborn babies whose mothers have chlamydia can get it during birth, causing serious eye infections and pneumonia (a serious lung infection).

## What are the signs and symptoms of chlamydia?

#### About 8 out of 10 WOMEN with chlamydia have NO SYMPTOMS!

If you do have symptoms, they could include:

- → Fluid from the vagina that smells, looks, or feels different
- → Bleeding from the vagina or the anus that is not normal
- → Pain with urination (peeing)
- → Lower stomach pain, especially when having sex

#### About 5 out of 10 MEN with chlamydia have NO SYMPTOMS!

If you do have symptoms, they could include:

- → Fluid from the head of the penis or the anus that is not normal
- → Pain or itching on the head of the penis
- → Pain with urination (peeing)

Even without symptoms, a person with chlamydia CAN GIVE chlamydia to their sex partner(s).

## Is chlamydia serious?

- → Yes! Even without pain or other symptoms, chlamydia can cause serious damage.
- → Women who have chlamydia can get Pelvic Inflammatory Disease (PID), a very bad infection in the lower abdomen. PID happens when the bacteria move up into the womb, female organs and surrounding areas. PID can cause scarring that makes a woman infertile (unable to have children). PID can also make a woman more likely to have a "tubal pregnancy," which can cause death.
- → Men can sometimes develop an infection of the testicles and scrotum (sack) that causes pain and swelling.
- → **Newborns** can develop serious eve and lung infections.
- → **Plus,** a person with chlamydia has a greater chance of giving or getting HIV, the virus that causes AIDS.

- → Your health care provider will give you medicine to cure chlamydia infection.
- → If you have chlamydia, your partner(s) must be treated even if they have no symptoms. If they are not treated, they can give the infection back to you, or infect others.
- → If you are pregnant or think you may be pregnant, be sure to tell your doctor or nurse.

# How can I avoid getting chlamydia?

- ✓ Abstinence (not having sex) is the only sure way to avoid infection.
- ✓ Plan Ahead: Think about protecting yourself. Talk about STDs and the need to protect yourself with your sex partner(s).
- ✓ Use a male condom with each sex partner.
- ✓ If a male condom cannot be used properly, the female condom can be used.

## **HIV** is also a **STD!**

When you get infected with chlamydia, you could also be getting HIV. Birth control pills or a birth control shot cannot protect you against chlamydia or other STDs.

Using **condoms** correctly every time you have sex can protect you from Chlamydia, HIV and other STDs.

#### WHERE CAN I GET MORE INFORMATION ABOUT STDs and PROTECTING MYSELF?

In English, Call toll free: National STD/HIV hotlines at 1+(800) 342-2437 or 1+(800) 227-8922.

In Spanish, Call toll free: 1+(800) 344-7432 TTY for the Deaf and Hard of Hearing: 1+(800) 243-7889

Talk to your health care provider or call your county health department. Look for the telephone number in the phone book (white pages) under county government. Ask to speak to someone in the STD clinic or the STD program for more information about chlamydia.

# The CONTRACEPTION Report



# Questions and Answers about Your First Pelvic Exam

#### What is a pelvic exam?

A pelvic examination is looking at and feeling the size and shape of the external and internal reproductive organs. These include the vulva (outside), and vagina, uterus, ovaries and fallopian tubes (inside).

#### Why do I need one?

The exam helps to make sure that your reproductive organs are healthy. It also helps your health care provider detect medical conditions (such as infections or abnormal Pap smears) that could become serious if not treated. Many clinicians recommend that you have your first pelvic exam when you become sexually active or reach the age of 18 years.

#### Will it hurt?

The pelvic examination will not hurt. Many women describe the experience as a sensation of crowding or fullness in the vagina; however, there should be no pain. Sometimes a woman will feel discomfort, especially if she is tense.

#### I feel scared to have one. Do other women feel this way?

It is normal to feel uncomfortable, embarrassed, or even scared. Many women complain that the most objectionable part of the exam is that it feels undignified to have to expose one's genitals to a stranger. You may be less embarrassed if you remember your clinician is highly trained and has probably performed hundreds or thousands of exams. The exam is not an emotional or sexual experience for the clinician. It is okay to have someone with you, such as your mother or close girlfriend.

#### Do I have to take off all my clothes?

Ordinarily, yes. You will be given a gown and asked to remove your clothes, including your bra and panties. You can undress in privacy and put on the gown before the clinician comes in for the exam.

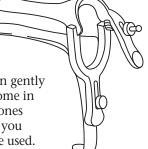
#### What will it feel like?

You will feel touching with gloved fingers on the outside of your genitals. During the bimanual exam you will feel two fingers in the vagina and the other hand on the abdomen gently pressing the tissue between the two hands. At one point during the exam, the clinician will insert an instrument called

a speculum into the vagina. The speculum will generally be warmed to minimize discomfort. Clinicians will commonly complete the exam by doing a rectal examination, placing one finger in the rectum and one finger in the vagina. The reason for this is the clinician can feel much higher and deeper in the pelvis to make sure everything is normal.

#### What is a speculum and why is it used?

A speculum is an instrument designed to spread the walls of the vagina open gently so that the clinician can see inside. Speculums (made of metal or plastic) come in many shapes and sizes to fit a woman's reproductive anatomy. The plastic ones sometimes make clicking noises when opened. Should the speculum cause you discomfort, tell your clinician immediately; often a smaller speculum can be used.



The Speculum

Note: This material is not under copyright. Feel free to duplicate and distribute to your patients.

#### If I'm a virgin, do I still need a pelvic exam?

If you are a virgin, it is important to have a pelvic exam if you have not begun to menstruate around the same time as other young women your own age, or if you have had problems with bleeding, pain or discharge. You will still be a virgin after the exam. Women who have used tampons for menstrual hygiene may find the first pelvic exam easier than those who have used external protection such as pads or panty liners.

#### What is a Pap test?

A Pap test or Pap smear is a screening test that helps clinicians detect cellular changes in the cervix (the opening to the womb at the end of the vagina). The Pap smear includes taking a sample of cells by wiping or scraping a small wooden stick (similar to a tongue depressor) over the cervix. The cells are then put on a glass slide and examined by laboratory personnel to look for changes that might warrant further investigation. During the Pap smear you will feel the swab being wiped across the cervix; this feels somewhat scratchy, but is not painful.

It's important to understand that the Pap test is a screening test only. Clinicians do not base treatments on the Pap test, but use it to determine whether further diagnostic tests are needed. The reason a Pap test is done is to detect changes *before* they can become cancer. If your Pap test is abnormal, don't be alarmed. Many women incorrectly believe an abnormal Pap test means they have cancer. In fact, the cause of 90% of cervical cell changes is a virus called human papillomavirus (HPV). Most conditions detected by an abnormal Pap test are minor and easily treated in the office.

#### How often do I need to get a Pap test?

The frequency of your Pap smear depends on your age and other factors. You should discuss how often you need a Pap test with your clinician.



# What is the most common position for the pelvic exam?

Various positions can be used for a pelvic exam; however, the most common one is laying on your back with your feet resting in foot rests, called stirrups. You will be asked to move your buttocks down to the end of the table and let your knees fall wide apart. The reason for this position and the stirrups is to provide the clinician adequate access to the genital area.

#### What can I do to be more comfortable during the exam?

The reaction of many women to having fingers or a speculum placed in the vagina is to close the legs or squeeze the vaginal muscles. While it may be instinctive to clamp down, tensing the muscles often will make you more uncomfortable. The key to the pelvic exam is relaxation. Take slow, deep breaths and try to distract your mind to help you relax.

#### Can I see what is happening?

Ask your clinician if you can watch the exam. Many clinicians are happy to show women their external and internal organs and can use a hand held mirror to help you see. Please ask if you're interested.

#### How long will it take?

Generally, the whole exam takes no more than 5 minutes. Although no one likes to have the exam done, it is important to your health now and in the future. After the first exam almost everyone says it wasn't as bad as they had imagined. You can be proud of yourself for taking responsibility for your health.

## **Multilingual STD Education Resources**

#### Myths and Facts About Sexual Health

Multicultural Health Communication Service, GPO Box 1614, Sydney, NSW 2001, Australia

www.health.nsw.gov.au

Brochure is available in PDF format at http://www.mhcs.health.nsw.gov.au/health-public-affairs/mhcs/publications/5435.html

Languages available: Arabic, Chinese, Croatian, Italian, Korean, Macedonian, Portuguese, Russian, Spanish, Thai, Turkish, Vietnamese.

#### **Sexually Transmitted Diseases**

T.H.E. Clinic/Asian Health Project, 3860 West King Blvd., Los Angeles, CA 9008, 323-295-6571

Language available: Cambodian, Japanese, Lao, Tagalog, Thai, Vietnamese

#### Sex and Hygiene

T.H.E. Clinic/Asian Health Project, 3860 West King Blvd., Los Angeles, CA 9008, 323-295-6571

Language available: Cambodian, Japanese, Lao, Thai, Vietnamese

#### **STD Facts**

ETR Associates, PO Box 1830, Santa Cruz, Ca 95061-1830, (831), 438-4060 http://www.etr.org/pub/titles/browse.html

Language available: Chinese, Spanish

#### STD and Pregnancy: Ten Things You Should Know

Journeyworks Publishing, PO Box 8466, Santa Cruz, CA 95061-8466 Phone: 831-423-1400, Fax:831-423-8102 http://www.journeyworks.com/languages.htm

Language available: Vietnamese, Chinese, Spanish

#### Website for teens

#### **Advocates for Youth**

"Rights. Respect. Responsibility." is their motto. Information, training and advocacy regarding teen sexuality. Offers teens information on how to become involved in youth initiatives. Including a "Health and Well-Being" section which covers topics of body image, healthy relationships, contraceptives, and STIs. Wide range of topics in English, Spanish and French.

www.advocatesforyouth.org

#### Club Condom

Succinct STD information & link to get free condoms or purchase online. Good FAQs section.

www.clubcondom.com

#### **Family Doctor**

The American Association of Family Physicians web site. Gives information for teens about STDs including HIV. Including a way to search information by the symptom experience, ways to contact and other web sites that are reviewed by the physicians. http://familydoctor.org/x5414.xml

#### It's Your (sex) Life

Your Guide to Safe and Responsible Sex, a campaign by the Kaiser Foundation. http://www.itsyoursexlife.com/

#### I Wanna Know

American Social Health Association with answers to teens' questions about teens' sexual health and sexually transmitted diseases. Includes 'ask the expert' option. http://www.iwannaknow.org

#### **KidsHealth**

Created by the Nemours Foundation Center for Children's Health Media. "KidsHealth is one of the largest sites on the Web providing doctor-approved health information about children from before birth through adolescence.

Kidshealth has separate areas for kids, teens, and parents-each with its own design, age appropriate content, and tone. There are literally hundreds on in-depth articles and features. (Includes article on Pelvic exams) www.kidshealth.org

#### Massachusetts Department of Public Health

STD Clinic Website

http://www.state.ma.us/dph/cdc/std/divstd.htm

#### Noah Health

New York Online Access to Health. Information in English and Spanish; other multilingual resources. Links to the US Department of Health and Human Services. www.noah-health.org

#### Website for teens (continued)

#### Scarleteen

Very hip teen sexual health information, written in 'straight up' language... Includes chat room, news, parent section, great question and answer section.

www.scarleteen.com

#### SEX, ETC.

Sponsored by Network for Family Life Education. "A website by teens for teens... the online version of the nationally acclaimed newsletter." www.sxetc.org

#### Teen Advice

This web site offers materials on teen sexuality, pregnancy, STDs, peer pressure, etc. There are guides and interactive quizzes, so teens can do something while they are learning on these topics. It deals with some of the questions that kids really ask about. http://teenadvice.about.com

#### TeenScene

Sponsored by Advocates for Youth (AYF). Features information and facts, peer education opportunities, health resources, feature topics, and resources for GLBT youth. www.advocatesforyouth.org/teens/

#### Teen Wire

This is the teen site sponsored by Planned Parenthood. It includes information on STDs/STIs, abstinence, condoms, teen pregnancy, and ways to contact a community center .

www.teenwire.com

#### The Center for Young Women's Health

This Children's Hospital (Boston) web site includes the topics "Chlamydia" and "Information about Your First Pelvic Exam." www.youngwomenhealth.org

#### Sites specific to pelvic exams:

www.youngwomenshealth.org/pelvicinfo.html www.kidshealth.org/teen/sexual\_health/obgyn.html www.drkoop.com/family/childrens/teensterritory.asp?id=5924

This is a partial listing of comprehensive websites on continuum of health issues including adolescent sexuality. As with all sites, if you are not familiar with them, we suggest you browsing them before suggesting them to teens. We do not endorse these sites nor guarantee their content. We have included them as options to consider, or you may want to use other educational material... These sites were in existence in December 2003. There may have been changes since that time.

# Section Eleven: Copies of Relevant Legal Documents

# **Emergency treatment of minors**

#### Law Review Commentaries

Health services: An interpretation of the effect of statutory immunity on medical malpractice liability. 54 B.U.L.Rev. 931 (1974).

Parent-child relationship. Neil L. Chayet, 17 Ann.Surv.Mass.L. 107 (1970).

#### Library References

Chemical Dependents ⇔11. Infants ⇔13. WESTLAW Topic Nos. 76A, 211. C.J.S. Chemical Dependents § 12. C.J.S. Infants §§ 5, 92 to 98. Miscellaneous immunities, see M.P.S. vol. 37A, Nolan and Sartorio, § 552.

#### Comments.

Medical malpractice, statutory exceptions from civil liability, see M.P.S. vol. 14A, Simpson and Alperin, § 1883.

#### § 12F. Emergency treatment of minors

No physician, dentist or hospital shall be held liable for damages for failure to obtain consent of a parent, legal guardian, or other person having custody or control of a minor child, or of the spouse of a patient, to emergency examination and treatment, including blood transfusions, when delay in treatment will endanger the life, limb, or mental well-being of the patient.

Any minor may give consent to his medical or dental care at the time such care is sought if (i) he is married, widowed, divorced; or (ii) he is the parent of a child, in which case he may also give consent to medical or dental care of the child; or (iii) he is a member of any of the armed forces; or (iv) she is pregnant or believes herself to be pregnant; or (v) he is living separate and apart from his parent or legal guardian, and is managing his own financial affairs; or (vi) he reasonably believes himself to be suffering from or to have come in contact with any disease defined as dangerous to the public health pursuant to section six of chapter one hundred and eleven; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease.

Consent shall not be granted under subparagraphs (ii) through (vi), inclusive, for abortion or sterilization.

Consent given under this section shall not be subject to later disaffirmance because of minority. The consent of the parent or legal guardian shall not be required to authorize such care and, notwithstanding any other provisions of law, such parent or legal guardian shall not be liable for the payment for any care rendered pursuant to this section unless such parent or legal guardian has expressly agreed to pay for such care.

No physician or dentist, nor any hospital, clinic or infirmary shall be liable, civilly and criminally, for not obtaining the consent of the parent or legal guardian to render medical or dental care to a minor, if, at the time such care was rendered, such person or facility: (i) relied in good faith upon the representations of such minor that he is legally able to consent to such treatment under this section; or (ii) relied in good faith upon the representations of such minor that he is over eighteen years of age.

#### PROFESSIONS AND OCCUPATIONS

All information and records kept in connection with the medical or dental care of a minor who consents thereto in accordance with this section shall be confidential between the minor and the physician or dentist, and shall not be released except upon the written consent of the minor or a proper judicial order. When the physician or dentist attending a minor reasonably believes the condition of said minor to be so serious that his life or limb is endangered, the physician or dentist shall notify the parents, legal guardian or foster parents of said condition and shall inform the minor of said notification.

Added by St.1970, c. 847. Renumbered by St.1971, c. 335, § 1. Amended by St.1975, c. 564.

#### Historical and Statutory Notes

St.1970, c. 847, approved Aug. 31, 1970, added the provisions of this section as c. 112, § 12E, without reference to the enactment of c. 112, § 12E by St.1970, c. 816.

St.1971, c. 335, § 1, approved May 27, 1971, renumbered the provisions of this section from c. 112, § 12E.

St.1975, c. 564, rewrote the section, which prior thereto read:

"No physician shall be held liable for damages for failure to obtain consent of a parent or parents, guardian or guardians or other persons

having custody or control of a minor child, or of the spouse of a patient, to emergency examination and treatment, including blood transfusions, when delay in treatment will endanger the life, limb, or mental well-being of the patient nor shall any hospital be liable for any such examination and treatment by a physician therein."

St.1975, c. 564, was approved Aug. 28, 1975. Emergency declaration by the Governor was filed Oct. 29, 1975.

#### Code of Massachusetts Regulations

Department of mental health, standards to promote client dignity, see 104 CMR 15.03. Mental retardation, standards to promote client dignity, legal rights of clients, see 104 CMR 20.05.

#### Law Review Commentaries

Constitution and family. 93 Harv.L.Rev. 1156 (1980).

Law of patient care. Michael Broad, 68 Mass.L.Rev. 10 (1983).

Parental consent and rights of minors to contraceptives. 88 Harv.L.Rev. 1001 (1975).

Voluntary sterilization of non-institutionalized mentally incompetent individual. 17 New Eng. L.Rev. 527 (1982).

#### Library References

Physicians and Surgeons ←16.
WESTLAW Topic No. 299.
C.J.S. Physicians, Surgeons, and Other
Health-Care Providers §§ 70, 81 to 86, 97

to 102.

Medical malpractice, statutory exemptions from civil liability, see M.P.S. vol. 14A, Simpson and Alperin, § 1883. Miscellaneous immunities, see M.P.S. vol. 37A, Nolan and Sartorio, § 552.

Pregnant minor child and abortion, see M.P.S. vol. 3, Kindregan and Inker, § 2288.

Forms.

Medical malpractice, see M.P.S. vol. 10, Rodman, § 1371.

# **Records pertaining to venereal diseases**

#### Historical and Statutory Notes

St.1894, c. 511, § 3. R.L.1902, c. 75, § 41. St.1906, c. 365, § 1.

#### § 119. Records pertaining to venereal diseases

Hospital, dispensary, laboratory and morbidity reports and records pertaining to venereal diseases, as defined under section six, shall not be public records, and the contents thereof shall not be divulged by any person having charge of or access to the same, except upon proper judicial order or to a person whose official duties, in the opinion of the commissioner, entitle him to receive information contained therein. Violations of this section shall for the first offence be punished by a fine of not more than fifty dollars, and for a subsequent offence by a fine of not more than one hundred dollars. Amended by St.1948, c. 129, § 5.

#### Historical and Statutory Notes

St.1905, c. 330, § 3. St.1918, c. 96, §§ 1, 3. St.1919, c. 350, § 97.

#### Cross References

Hospital records as evidence, see c. 111, § 70; c. 233, § 79.

#### Code of Massachusetts Regulations

Sexually transmitted diseases, reporting and control, see 105 CMR 340.001 et seq.

#### Law Review Commentaries

Compliance with medical records subpoenas. Nancy R. Rice and Steven M. Sayers, 27 Boston B.J. No. 8, p. 12 (1983).

#### Library References

Health and Environment €=34. WESTLAW Topic No. 199. C.J.S. Health and Environment §41. Hospital records, order for inspection and copies, see M.P.S. vol. 12, Martin and Hennessey, § 1852.

#### Notes of Decisions

In general 1

1. In general

Provisions of statute do not relate to the public records relative to deaths, and city or town clerk receiving facts relative to deaths, giving gonorrhea or syphilis as the disease or cause of death, is not prohibited from entering such facts in the record of death and from subsequently issuing a certificate containing such facts. 8 Op.Atty.Gen.1929, p. 600.

Meaning of "endanger life or limb"

Memorandum

To: Susan Stein, First Deputy General Counsel

From: Scott Mays

07/02/03

Re: Meaning of "endanger life or limb" as applied to M.G.L. c. 112 § 12F.

In the Commonwealth of Massachusetts there are limited circumstances when a minor may give their consent for medical treatment. One such circumstance is when a minor believes that he/she is suffering from or has been exposed to a disease dangerous to the Public Health. M.G.L. c. 112 § 12F (vi). Specifically, the issue revolves around minors who wish to be tested and receive treatment for sexually transmitted diseases (STDs).

Section 12F also requires that if the minor's condition is so serious that his life or limb is endangered, the physician is required to notify the minor's parents or legal guardians. M.G.L. c. 112 § 12F. The physician must reasonably believe that the minor's life or limb is endangered. <u>Id.</u> (emphasis added). By the construction of the statute then, the physician is required to report to the minor's parents or guardians if in his medical judgment; the minor's life or limb is endangered. The question is what constitutes "endangered life or limb".

There is no case law in Massachusetts that is directly on-point with this issue. The statute in question seems to be cited the most in cases dealing with minors seeking an abortion and the related parental notification rights. See Baird v. Attorney General, 371 Mass. 741 (1997); In Re Rena, 46 Mass. App. 365 (1999).

In <u>Baird</u>, the Massachusetts Supreme Judicial Court (SJC) says that the grounds for a minor consenting to an abortion are the same as the grounds for a minor consenting to any other medical procedure in that in both instances, "a physician must exercise his or her medical judgment and the minor must consent to the procedure as being in his or her best interests". <u>Baird</u>, 371 Mass. at 760-761.

In the absence of explanatory language within section 12F, one is left to construe "endanger life or limb" based on its common understanding. Endanger life or limb is commonly thought to refer to the danger of serious bodily harm or death. There are no recent cases that specifically deal with the definition of "endanger life or limb". In an older case, the SJC refers to the fear of loss of life or limb as the fear of "remediless harm to the person". Silsbee v. Webber, 171 Mass. 378, 383 (1891).

If a minor were being treated by a physician in Massachusetts for a sexually transmitted disease, then according to section 12F, the only way that the parents or guardians of the minor would have to be notified is if the physician *reasonably believes* that the minor is in danger of losing life or limb. M.G.L. c. 112 § 12F (emphasis added). This is to say that it is within the judgment of the physician as to whether or not the sexually transmitted disease or complications related to the disease constitute a risk of serious bodily harm or death. If the physician reasonably believes this to be the case, then he or she is obligated to inform the parents or guardians of the minor. <u>Id.</u>

It is possible that the statute is intentionally vague regarding what would constitute endangerment of life or limb. The reasoning behind this decision would appear to be that endangerment of life or limb is a determination made by the physician in his or her professional judgment.

There is a law similar to section 12F which is found in the State of New York.

New York State law allows a physician to treat a minor without the notification or consent of the minor's parents if the minor believes they have been exposed to or are suffering from a sexually transmissible disease. N.Y. Pub Health § 2305 (Consol. 2003). Like the Massachusetts statute, the New York law seeks to give minors an opportunity to seek testing and treatment for STDs without notifiying the minor's parents. The rationale is that the lack of a notification requirement will encourage more minors who may have been exposed to STDs to seek testing and treatment. Rhonda G. Hartman, Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices, 8 U Chi L Sch Roundtable 87, 88 (2001).

If a physician did not notify parents in this situation, and the matter was litigated, a court would have to determine if the physician's judgment was sound in his or her decision not to notify. The court would ultimately be balancing the parents' interest in being notified with "policy concerns of preventing endangerment to the health and welfare of adolescents and other persons potentially affected by an adolescent's disease". Id. at 92.

# **HLTV-III Test; Confidentiality; informed consent**

#### Note 2

request of guardian. Brophy v. New England Sinai Hosp., Inc. (1986) 497 N.E.2d 626, 398 Mass 417

A distinct adjudication of incapacity of an involuntarily committed mental patient to make treatment decisions, incompetence, must precede any determination to override the patient's right to make his own treatment decisions. Rogers v. Commissioner of Dept. of Mental Health (1983) 458 N.E.2d 308, 390 Mass. 489.

An involuntarily committed mental patient has the right to make treatment decisions and does not lose that right until he is adjudicated incompetent by a judge through incompetence proceedings. Rogers v. Commissioner of Dept. of Mental Health (1983) 458 N.E.2d 308, 390 Mass. 489.

No state interest is sufficiently compelling in a nonemergency situation to overcome a decision of an incompetent mental patient to refuse treatment with antipsychotic drugs. Rogers v. Commissioner of Dept. of Mental Health (1983) 458 N.E.2d 308, 390 Mass. 489. In making a substituted judgment decision to forcibly medicate an involuntarily committed mental patient with antipsychotic drugs, the judge should consider the patient's express preferences regarding treatment, the strength of the patient's convictions to the extent that they may contribute to his refusal of treatment, the impact of the decision on the patient's family, to probability of adverse side effects, the prognosis with and without treatment, and any other relevant factors. Rogers v. Commissioner of Dept. of Mental Health (1983) 458 N.E.2d 308, 390 Mass. 489.

#### 3. Blood test results

Admitting results of blood alcohol test performed during course of routine medical treatment for injuries from automobile accident in prosecution of defendant for driving while under the influence of intoxicating liquor did not violate defendant's rights against interference with his privacy or to confidentiality of hospital records and communications. Com. v. Dube (1992) 601 N.E.2d 467, 413 Mass. 570.

#### § 70F. HLTV-III test; confidentiality; informed consent

No health care facility, as defined in section seventy E, and no physician or health care provider shall (1) test any person for the presence of the HTLV-III antibody or antigen without first obtaining his written informed consent; (2) disclose the results of such test to any person other than the subject thereof without first obtaining the subject's written informed consent; or (3) identify the subject of such tests to any person without first obtaining the subject's written informed consent.

No employer shall require HTLV-III antibody or antigen tests as a condition for employment.

Whoever violates the provisions of this section shall be deemed to have violated section two of chapter ninety-three A.

For the purpose of this section "written informed consent" shall mean a written consent form for each requested release of the results of an individual's HTLV-III antibody or antigen test, or for the release of medical records containing such information. Such written consent form shall state the purpose for which the information is being requested and shall be distinguished from written consent for the release of any other medical information, and for the purpose of this section "HTLV-III test" shall mean a licensed screening antibody test for the human T-cell lymphotrophic virus type III.

Added by St.1986, c. 241.

#### Historical and Statutory Notes

St.1986, c. 241, was approved July 15, 1986.

Persons required to report cases of injured, abused, or neglected children

#### LEXSTAT Mass. Ann. Laws ch. 119 @ 51A

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\*\*\* THIS DOCUMENT IS CURRENT THROUGH CHAPTER 22, 6/12/03 \*\*\*

#### PART I. ADMINISTRATION OF THE GOVERNMENT

#### TITLE XVII. PUBLIC WELFARE

CHAPTER 119. PROTECTION AND CARE OF CHILDREN, AND PROCEEDINGS AGAINST THEM

[ABUSED OR NEGLECTED CHILDREN]

#### GO TO MASSACHUSETTS CODE ARCHIVE DIRECTORY

Mass. Ann. Laws ch. 119, § 51A (2003)

§ 51A. Persons Required to Report Cases of Injured, Abused, or Neglected Children; Immunity; Privilege; Penalty.

Any physician, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner, psychologist, emergency medical technician, dentist, nurse, chiropractor, podiatrist, optometrist, osteopath, public or private school teacher, educational administrator, guidance or family counselor, day care worker or any person paid to care for or work with a child in any public or private facility, or home or program funded by the commonwealth or licensed pursuant to the provisions of chapter twenty-eight A, which provides day care or residential services to children or which provides the services of child care resource and referral agencies, voucher management agencies, family day care systems and child care food programs, probation officer, clerk/magistrate of the district courts, parole officer, social worker, foster parent, firefighter or policeman, licensor of the office of child care services or any successor agency, school attendance officer, allied mental health and human services professional as licensed pursuant to the provisions of section one hundred and sixty-five of chapter one hundred and twelve, drug and alcoholism counselor, psychiatrist, and clinical social worker, priest, rabbi, clergy member, ordained or licensed minister, leader of any church or religious body, accredited Christian Science practitioner, person performing official duties on behalf of a church or religious body that are recognized as the duties of a priest, rabbi, clergy, ordained or licensed minister, leader of any church or religious body, or accredited Christian Science practitioner, or person employed by a church or religious body to supervise, educate, coach, train or counsel a child on a regular basis, who, in his professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department by oral communication and by making a written report within forty-eight hours after such oral communication; provided, however, that whenever such person so required to report is a member of the staff of a medical or other public or private institution, school or facility, he shall immediately either notify the department or notify the person in charge of such institution, school or facility, or that person's designated agent, whereupon such person in charge or his said agent shall then become responsible to make the report in the manner required by this section. Any such hospital personnel preparing such report, may take, or cause to be taken, photographs of the areas of trauma visible on a child who is the subject of such report without the consent of the child's parents or guardians. All such photographs or copies thereof shall be sent to the department together with such report. Any such person so required to make such oral and written reports who fails to do so shall be punished by a fine of not more than one thousand dollars. Any person who knowingly files a report of child abuse that is frivolous shall be punished by a fine of not more than one thousand dollars.

Said reports shall contain the names and addresses of the child and his parents or other person responsible for his care, if known; the child's age; the child's sex; the nature and extent of the child's injuries, abuse, maltreatment, or neglect, including any evidence of prior injuries, abuse, maltreatment, or neglect; the circumstances under which the person required to report first became aware of the child's injuries, abuse, maltreatment or neglect; whatever action, if any, was taken to treat, shelter, or otherwise assist the child; the name of the person or persons making such report; and any other information which the person reporting believes might be helpful in establishing the cause of the injuries; the identity of the person or persons responsible therefor; and such other information as shall be required by the department.

Any person required to report under this section who has reasonable cause to believe that a child has died as a result of any of the conditions listed in said paragraph shall report said death to the department and to the district attorney for the county in which such death occurred and to the medical examiners as required by section six of chapter thirty-eight. Any such person who fails to make such a report shall be punished by a fine of not more than one thousand dollars.

In addition to those persons required to report pursuant to this section, any other person may make such a report if any such person has reasonable cause to believe that a child is suffering from or has died as a result of such abuse or neglect. No person so required to report shall be liable in any civil or criminal action by reason of such report. No other person making such report shall be liable in any civil or criminal action by reason of such report if it was made in good faith; provided, however, that such person did not perpetrate or inflict said abuse or cause said neglect. Any person making such report who, in the determination of the department or the district attorney may have perpetrated or inflicted said abuse or cause said neglect, may be liable in a civil or criminal action.

No employer of those persons required to report pursuant to this section shall discharge, or in any manner discriminate or retaliate against, any person who in good faith makes such a report, testifies or is about to testify in any proceeding involving child abuse or neglect. Any such employer who discharges, discriminates or retaliates against such a person shall be liable to such person for treble damages, costs and attorney's fees.

Within sixty days of the receipt of a report by the department from any person required to report, the department shall notify such person, in writing, of its determination of the nature, extent and cause or causes of the injuries to the child, and the social services that the department intends to provide to the child or his family.

Any privilege established by sections one hundred and thirty-five A and one hundred and thirty-five B of chapter one hundred and twelve or by section sections 20A and 20B of chapter two hundred and thirty-three, relating to confidential communications shall not prohibit the filing of a report pursuant to the provisions of this section or the provisions of section twenty-four.

Notwithstanding section 20A of chapter 233, a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner shall report all cases of abuse under this section, but need not report information solely gained in a confession or similarly confidential communication in other religious faiths. Nothing in the general laws shall modify or limit the duty of a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner to report a reasonable cause that a child is being injured as set forth in this section when the priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body or accredited Christian Science practitioner is acting in some other capacity that would otherwise make him a reporter.

HISTORY: 1973, 1076, § 5; 1975, 276, § 4; 1977, 501; 1977, 942; 1978, 215, § 1; 1979, 312, § 1; 1980, 434; 1981, 91, § 2; 1982, 102; 1983, 222; 1984, 83, § 1, 2; 1985, 209; 1985, 209; 1986, 230, § § 1, 2; 1989, 219; 1989, 535, § 5; 1990, 474, § 1; 1991, 280; 1992, 115, § 1; 1993, 50, § 23; 1997, 197; 2002, 107, § § 1-4, approved with emergency preamble, May 3, 2002

#### NOTES:

#### EDITORIAL NOTE--

The 1975 amendment increased the upper age limit from 16 to 18 years.

The first 1977 amendment, (Ch. 501), inserted the second sentence of the third paragraph, to provide that any enumerated person who fails to report child abuse cases shall be punished by a fine of not more than \$1,000.

## Case Summary: Albert v. Devine

Source: My Sources > / . . . / > MA State Cases, Combined (1)

Terms: name(alberts and devine) and date(geq (1/01/85) and leq (12/31/85)) (Edit Search)

395 Mass. 59, \*; 479 N.E.2d 113, \*\*; 1985 Mass. LEXIS 1551, \*\*\*

William E. **Alberts** v. Donald T. **Devine** & others n1 n1 Edward G. Carroll and John E. Barclay.

No. N-3624

Supreme Judicial Court of Massachusetts

395 Mass. 59; 479 N.E.2d 113; 1985 Mass. LEXIS 1551

October 5, 1984, Argued June 4, 1985, Decided

PRIOR HISTORY: [\*\*\*1]

Norfolk.

Civil action commenced in the Superior Court on March 4, 1975.

A motion to dismiss, a motion to amend the complaint, and motions for summary judgment were heard by *Elizabeth J. Dolan*, J., and questions of law were reported by her to the Appeals Court. The Supreme Judicial Court transferred the case on its own initiative.

**DISPOSITION:** So ordered.

#### **CASE SUMMARY**

**PROCEDURAL POSTURE:** Plaintiff minister brought an action against defendants, psychiatrist and two church superiors, for disclosure of confidential information without the minister's approval, which resulted in financial losses, damage to his reputation, and mental anguish. After dismissing the two church leaders, the trial court reported four questions to the Appeals Court (Massachusetts), which referred the matter to the court.

**OVERVIEW:** In deciding the four questions reported by the trial court, the court found: (1) in regard to a physician's duty not to disclose confidential information, the court found a duty of confidentiality arose from the physician-patient relationship and that a violation of that duty, resulting in damages, gave rise to a cause of action sounding in tort against the physician; (2) on the nonstatutory invasion of privacy, the court did not recognize a common law right of privacy, finding that that right would not have permitted recovery beyond the recovery available for a physician's violation of the duty of confidentiality recognized above, and for inducement of such a violation recognized below; (3) a plaintiff may have held liable one who had intentionally induced another to commit a tortious act that resulted in damage to the plaintiff; (4) the First Amendment freedom of religion clause did not preclude the imposition of liability on the two church leaders; (5) the First Amendment did not preclude the examination of proceedings that resulted in the minister's failure to gain reappointment.

**OUTCOME:** The court answered "yes" to question one, no answer to question two was required, and answered "no" to questions three and four.

**CORE TERMS:** patient, duty, confidentiality, church, physician-patient, First Amendment, disclosure, disclose, religion, privacy, induce, cause of action, medical information, imposition of liability, invasion of privacy, hether, psychiatrist, owe, doctor, reappointment, summary judgment, protective order, public policy, appointment, memorandum, disclose information, confidential communications, free exercise of religion, confidential information, subject to liability

#### LexisNexis(TM) HEADNOTES - Core Concepts - \* Hide Concepts

- Evidence > Privileges > Doctor-Patient Privilege
- Unless faced with a serious danger to the patient or to others, a physician owes a patient a duty not to disclose without the patient's consent medical information about the patient gained in the course of the professional relationship, and the violation of that duty gives rise to a civil action for whatever damages flow therefrom.
- Evidence > Privileges > Doctor-Patient Privilege
- HN2 A civil action will lie against anyone who, with the requisite state of mind, induces a violation of the physician's duty of confidentiality and thereby causes injury or loss to the patient.
- Constitutional Law > Fundamental Freedoms > Freedom of Religion
- The religion clauses of the First Amendment made applicable to the states by the Fourteenth Amendment, do not preclude inquiry by the courts of the commonwealth into church processes regarding the appointment and the discharge of ministers, nor do those clauses preclude the imposition of liability on the clerical defendants.
- Constitutional Law > Fundamental Freedoms > Freedom of Religion

  HN4

  ★ See U.S. Const. amend. I.
- Civil Procedure > Appeals > Appellate Jurisdiction > Certified Questions

  \*\*HN5\*\* After verdict or after a finding of facts under Mass. R. Civ. P. 52 if the judge is of opinion that an interlocutory finding or order made by her so affects the merits of the controversy that the matter ought to be determined by the appeals court before any further proceedings in the trial court, the judge may report such matter, and may stay all further proceedings except such as are necessary to preserve the rights of the parties. Mass. R. Civ. P. 64. Under the rule, a trial judge may report a matter that ought to be determined at the appellate level before judgment is entered or before further proceedings take place. In essence, the word report connotes a suspension of the trial court's function pending decision by an appellate court.
- Evidence > Privileges > Doctor-Patient Privilege
- \*A patient should be entitled to freely disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled.
- Evidence > Privileges > Doctor-Patient Privilege
- To foster the best interest of the patient and to insure a climate most favorable to a complete recovery, men of medicine urge that patients be totally frank in their discussions with their physicians. To encourage the desired candor, men of law formulate a strong policy of confidentiality to assure patients that only they themselves may unlock the doctor's silence in regard to those private disclosures.

The result which these joint efforts of the two professions produce is urged or forecast in una voce by commentators in the field of medical jurisprudence.

### Evidence > Privileges > Doctor-Patient Privilege

The courts that impose on physicians a duty of confidentiality and recognize a cause of action to enforce that duty ground their decisions on the determination that public policy favors the protection of a patient's right to confidentiality. Courts find indications of that public policy in statutes creating a testimonial privilege with respect to confidential communications between a patient and a physician and in licensing statutes that authorize the suspension or revocation of a license to practice medicine if a doctor divulges a professional secret without authorization. The absence of statutes of that type, however, does not indicate that no public policy favoring a patient's right to confidentiality exists.

#### Evidence > Privileges > Doctor-Patient Privilege

In Massachusetts, the legislature demonstrates its recognition of a policy favoring confidentiality of medical facts by enacting Mass. Gen. Laws. ch. 111,§§ 70 and 70E, to limit the availability of hospital records. Furthermore, Mass. Gen. Laws ch. 233, § 20B, creates an evidentiary privilege as to confidential communications between a psychotherapist and a patient. The fact that no such statutory privilege obtains with respect to physicians generally and their patients, does not dissuade the court from declaring that in this commonwealth all physicians owe their patients a duty, for violation of which the law provides a remedy, not to disclose without the patient's consent medical information about the patient, except to meet a serious danger to the patient or to others.

### Governments > Courts > Authority to Adjudicate

The courts must, and do, have the continuing power and competence to answer novel questions of law arising under ever changing conditions of the society which the law is intended to serve.

## Evidence > Privileges > Doctor-Patient Privilege

The contractual relationship between a physician and a patient there arises a fiduciary obligation to hold in trust confidential information.

## Evidence > Privileges > Doctor-Patient Privilege

Torts > Negligence > Duty > Duty Generally

\*A duty of confidentiality arises from the physician-patient relationship and that a violation of that duty, resulting in damages, gives rise to a cause of action sounding in tort against the physician.

Torts > Defamation & Invasion of Privacy > Constitutional Privileges

HN13

★ See Mass. Gen. Laws ch. 214, § 1B.

#### Torts > Defamation & Invasion of Privacy

One who, with the state of mind induces a physician wrongfully to disclose information about a patient, may be held liable to the patient for the damages that flow from that disclosure. The inducement need not be a threat, nor a promise of reward, but may be a simple request or persuasion exerting only moral pressure.

## Evidence > Privileges > Doctor-Patient Privilege

Torts > Defamation & Invasion of Privacy

HN15 To establish liability the plaintiff must prove that: (1) the defendant knows or

reasonably should know of the existence of the physician-patient relationship; (2) the defendant intends to induce the physician to disclose information about the patient or the defendant reasonably should anticipate that his actions would induce the physician to disclose such information; and (3) the defendant does not reasonably believe that the physician could disclose that information to the defendant without violating the duty of confidentiality that the physician owes the patient.

#### Torts > Damages

- HN16 A plaintiff may hold liable one who intentionally induces another to commit any tortious act that results in damage to the plaintiff.
- Constitutional Law > Fundamental Freedoms > Freedom of Religion
  HN17★ The First Amendment prohibits civil courts from intervening in disputes concerning religious doctrine, discipline, faith, or internal organization.
- Constitutional Law > Fundamental Freedoms > Freedom of Religion
  HN18★ The assessment of an individual's qualifications to be a minister, and the appointment and retirement of ministers, are ecclesiastical matters entitled to constitutional protection against judicial or other State interference.
- Constitutional Law > Fundamental Freedoms > Freedom of Religion
  HN19★ Although the freedom to believe is absolute, the freedom to act cannot be.
  Conduct remains subject to regulation for the protection of society. The freedom to act must have appropriate definition to preserve the enforcement of that protection.
- Constitutional Law > Fundamental Freedoms > Freedom of Religion

  HN20 ★ A law, legislatively or judicially created, that would regulate or prevent religiously motivated conduct does not violate the First Amendment if the state's interest in the law's enforcement outweighs the burden that the law imposes on the free exercise of religion. A determination of constitutionality requires a balancing of the competing interests.

#### Show Headnotes

**COUNSEL:** Robert J. Doyle (Bruce V. Keary with him) for the plaintiff.

Florence E. Freeman for John E. Barclay.

Deborah S. Griffin & Ripley E. Hastings for Edward G. Carroll & another.

Jared H. Adams for Donald T. Devine.

Ann M. Gilmore, for Ad-Hoc Committee of Methodist Ministers [\*\*\*4] on the Separation of Church and State, amicus curiae, submitted a brief.

JUDGES: Hennessey, C.J., Wilkins, Abrams, Nolan, & O'Connor, JJ.

**OPINIONBY: O'CONNOR** 

**OPINION:** [\*60] [\*\*115] In this action, brought by William E. Alberts, a minister of the United Methodist Church, against Donald T. Devine, a psychiatrist, and Edward G. Carroll and John E. Barclay, two of the plaintiff's clerical superiors, we hold that: (1) HN1 unless faced

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n2 HN4 Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . . "

n3 No contention has been made that the Constitution of the Commonwealth provides to any of the defendants greater protection than does the Constitution of the United States. Therefore, we do not consider any question of State constitutional law.

Alberts's amended complaint alleges that in April, 1973, and for some period of time before that, he was a minister with the Southern New England Conference of the United Methodist Church (conference), that he and the defendant Devine had entered into a contract for the provision of psychiatric services, and that implicit in their relationship was a [\*\*\*6] warranty that Devine would keep confidential "all information, observations and opinions relating to the diagnosis, condition, behavior, and treatment" of Alberts that Devine might gain in his professional capacity. The complaint further alleges that on or about April 9, 1973, in violation of that warranty and in violation of Devine's explicit promise, made during the course of treatment, to "respect the confidential nature of the relationship between doctor and patient," Devine disclosed to the defendant Carroll, Resident Bishop of the Boston Area of the United Methodist Church and President of the conference, or to Carroll's representative, information about Alberts's "diagnosis, condition, behavior or treatment." The complaint alleges that Carroll and the defendant Barclay, District Superintendent of the Greater Boston District of the conference, intentionally induced the disclosure, and that Carroll and Barclay "informed numerous individual members of the [conference], [\*62] as well as the various boards, committees and subcommittees of that Conference concerned with the appointment of its ministers to local churches, of their opinions of [Alberts's] mental health." Furthermore, [\*\*\*7] it is averred that Carroll expressed to the public and to news reporters his belief that Alberts "was mentally ill and therefore unappointable," and that his "belief was based on 'competent consultation.'" The complaint alleges that Carroll used the information he obtained from Devine to cause Alberts not to be reappointed as minister of the Old West Church in Boston, and that the unauthorized disclosures caused Alberts considerable loss of earning capacity and other financial losses, damage to his reputation, and great mental anguish requiring medical treatment.

The three defendants filed answers, and Carroll's and Barclay's answer, as amended, included the following defense: "The alleged actions by [Carroll and Barclay], if taken at all, were taken pursuant to their duties and authority as [Alberts's] superiors in the hierarchy of the United Methodist Church and as such are privileged and immune from inquiry by this Court under the First and Fourteenth Amendments of the United States Constitution."

The three defendants filed motions for summary judgment, and Devine filed a motion to dismiss. The judge allowed Carroll's and Barclay's motion for summary judgment, and she allowed [\*\*\*8] their motions for entry of judgment pursuant to Mass. R. Civ. P. 54 (b), 365 Mass. 820 (1974). She denied both of Devine's motions. The judge also denied a motion filed by Alberts to amend his complaint by adding a count for tortious interference with privacy rights. Carroll and Barclay filed a motion for a protective order quashing any subpoena that might be served on them in connection with a trial of the case or on "any other person who was a member of the United Methodist Church in 1972 or 1973." The motion further requested that the judge limit further disclosure of, and exclude from evidence at trial, deposition testimony previously given, and documents previously identified, by Carroll and Barclay or other named individuals associated with the United Methodist Church. Lastly, the motion requested that the judge rule inadmissible [\*63] at trial "any evidence relating in any way to the conduct, words and thoughts of defendants Barclay and Carroll and of any other members of the United [\*\*117] Methodist Church in 1972 or 1973." As grounds for their motion, Carroll and Barclay asserted a "constitutional prohibition of inquiry by the civil courts into matters of church [\*\*\*9] doctrine and administration." The judge allowed the motion in its entirety.

At the same time that she made those rulings, the judge reported the following questions to the Appeals Court: (1) "[W]hether disclosures [of confidential medical information] by a psychiatrist of a former patient constitutes a cognizable cause of action within the Commonwealth of Massachusetts"; (2) "[W]hether a cause of action for invasion of privacy existed within the Commonwealth of Massachusetts prior to July 1, 1974"; (3) "[W]hether the actions of the defendants Barclay and Carroll are within the ambit of the privileges and immunities granted by the First and Fourteenth Amendments of the United States Constitution"; and (4) "[W]hether [the judge] properly invoked the First Amendment in entering the protective order for defendants Barclay and Carroll." We transferred the case to this court on our own initiative.

Before reaching the reported questions, we must consider a procedural matter: In light of the judgments entered for Carroll and Barclay, do our answers to the reported questions have any significance with respect to Alberts's claims against them? HNST\*[A]fter verdict or after a finding [\*\*\*\*10] of facts under Rule 52 . . . [i]f [the judge] is of opinion that an interlocutory finding or order made by [her] so affects the merits of the controversy that the matter ought to be determined by the Appeals Court before any further proceedings in the trial court, [the judge] may report such matter, and may stay all further proceedings except such as are necessary to preserve the rights of the parties." Mass. R. Civ. P. 64, 365 Mass. 831 (1974). Under the rule, a trial judge may report a matter that ought to be determined at the appellate level before judgment is entered or before further proceedings take place. "In essence, the word 'report' connotes a suspension of the trial court's function pending decision by an appellate court." J.W. Smith & H.B. [\*64] Zobel, Rules Practice § 64.1 (1981). Rule 64 does not authorize a report after judgment.

It is not clear from the report nor from the judge's memorandum explaining the reasons for the report whether the judge intended that the answers to the reported questions would apply only to the claims against Devine or whether she also intended them to apply to the claims against Carroll and Barclay. In the memorandum, the [\*\*\*11] judge discusses the relevancy of the questions to the claims against Devine, suggesting that, in keeping with rule 64, the judge reported the case solely to expedite the disposition of the claims against Devine. For example, the judge explained that the questions involving the religion clauses are important to the claims against Devine because, in order to establish damages as to Devine, particularly with respect to loss of earnings, Alberts would have to show that the information allegedly disclosed by Devine contributed to Alberts's loss of employment. The judge also observed that, in order to present that proof, inquiry will be necessary into "the processes of appointment or nonappointment by the governing body of the church together with consideration by a civil court of the interpretation and application of certain codes or canons of

[the] church as embodied within its 'Book of Discipline.'" Other language in the memorandum, however, suggests that the judge intended that the Appeals Court's answers to the reported questions would also affect the claims against Carroll and Barclay. For example, the memorandum's concluding paragraph states: "The issues raised on the summary [\*\*\*12] judgments are reported after decision and entry of final judgments as to Barclay and Carroll and the issues raised on interlocutory matters of the plaintiff's motion to amend to add a count of invasion of privacy and the denial of the defendant Devine's motion to dismiss for failure to state a cause of action cognizable by this court are further reported due to the nature of the complaint as filed and the [\*\*118] status of the pleadings." Without arguing the procedural point, counsel for Carroll and Barclay have assumed that our answers to the questions will apply to Alberts's claims against them. In his brief, Alberts urges us to reverse the grant of summary judgment in favor of Carroll and Barclay, and, in [\*65] their briefs, Carroll and Barclay request that we affirm that grant. Carroll and Barclay also ask us to affirm the judge's denial of Alberts's motion to add to his complaint a common law claim for invasion of privacy. Although Alberts filed a timely claim of appeal from the entry of judgments in favor of Carroll and Barclay, he has not further perfected the appeal, apparently in reliance on the judge's report as a vehicle for review. See Mass. R. A. P. 5, as [\*\*\*13] appearing in 378 Mass. 930 (1979). In light of that reliance, fairness requires that we treat the claims against Carroll and Barclay as if they were here on appeal, with Alberts assigning as error the unfavorable rulings by the trial judge on the reported questions. Therefore, our answers to the questions affect Alberts's claims against Devine, Carroll, and Barclay.

Reported Question 1. A physician's duty not to disclose confidential information. Until this case, we have not confronted the question whether a patient has a nonstatutory, civil remedy against a physician if the physician, without the patient's consent, makes an out-of-court disclosure of confidential information obtained in the course of the physician-patient relationship. In Bratt v. International Business Machs. Corp., 392 Mass. 508 (1984), although we focused our attention on a different issue -- whether the disclosure of medical information concerning an employee to an employer by a company physician violated the employee's statutory right of privacy granted by G. L. c. 214, § 1B -- we "recognize[d] a patient's valid interest in preserving the confidentiality of medical facts relayed to a physician." [\*\*\*14] Id. at 522. We also quoted with approval in Bratt the New Jersey Supreme Court's statement that \*\*M6\*\*\*"[a] patient should be entitled to freely disclose his symptoms and condition to his doctor in order to receive proper treatment without fear that those facts may become public property. Only thus can the purpose of the relationship be fulfilled." \*Bratt v. International Business Machs. Corp., supra at 522-523, quoting Hague v. Williams, 37 N.J. 328, 336 (1962).

We continue to recognize a patient's valid interest in preserving the confidentiality of medical facts communicated to a physician or discovered by the physician through examination. [\*66] "The benefits which inure to the relationship of physician-patient from the denial to a physician of any right to promiscuously disclose such information are self-evident. On the other hand, it is impossible to conceive of any countervailing benefits which would arise by according a physician the right to gossip about a patient's health." Haque v. Williams, supra at 335-336. HN7 To foster the best interest of the patient and to insure a climate most favorable to a complete recovery, men of medicine have urged [\*\*\*15] that patients be totally frank in their discussions with their physicians. To encourage the desired candor, men of law have formulated a strong policy of confidentiality to assure patients that only they themselves may unlock the doctor's silence in regard to those private disclosures. The result which these joint efforts of the two professions have produced . . . has been urged or forecast in una voce by commentators in the field of medical jurisprudence." Hammonds v. Aetna Casualty & Sur. Co., 243 F. Supp. 793, 797 (N.D. Ohio 1965), and authorities cited therein. The Supreme Court of Oregon has recently held that a patient in that State has a civil right of recovery if a physician discloses without privilege confidential information obtained from the patient in the course of the physician-patient relationship. Humphers v. First Interstate Bank, 298 Or. 706 (1985). Patients in Massachusetts deserve no less protection.

Few cases consider the out-of-court physician-patient privilege. "That is undoubtedly [\*\*119] due to the fact that the confidentiality of the relationship is a cardinal rule of the medical profession, faithfully adhered to in most instances, [\*\*\*16] and thus has come to be justifiably relied upon by patients seeking advice and treatment." MacDonald v. Clinger, 84 A.D.2d 482, 483 (N.Y. 1982). Of the courts that have considered the question, most have held that a patient can recover damages if the physician violates the duty of confidentiality that plays such a vital role in the physician-patient relationship. See Humphers v. First Interstate Bank, supra; Horne v. Patton, 291 Ala. 701, 708-709 (1974); Simonsen v. Swenson, 104 Neb. 224, 227 (1920); Hague v. Williams, supra at 336; MacDonald v. Clinger, supra at 482; Hammonds v. Aetna Casualty [\*67] & Sur. Co., supra at 802 (Ohio law). Only three decisions have come to our attention in which courts have declined to recognize such a cause of action, and we do not find their reasoning persuasive. See Logan v. District of Columbia, 447 F. Supp. 1328, 1335 (D.D.C. 1978) (D.C. law); Collins v. Howard, 156 F. Supp. 322, 324 (S.D. Ga. 1957) (Georgia law); Quarles v. Sutherland, 215 Tenn. 651, 657 (1965).

\*The courts that have imposed on physicians a duty of confidentiality and have recognized a cause of action [\*\*\*17] to enforce that duty have grounded their decisions on the determination that public policy favors the protection of a patient's right to confidentiality. Courts have found indications of that public policy in statutes creating a testimonial privilege with respect to confidential communications between a patient and a physician and in licensing statutes that authorize the suspension or revocation of a license to practice medicine if a doctor divulges a professional secret without authorization. The absence of statutes of that type, however, does not indicate that no public policy favoring a patient's right to confidentiality exists. No testimonial privilege statute existed in Alabama when the Supreme Court of Alabama decided \*Horne v. Patton, supra.\* Nor did such a statute exist in New Jersey when the Supreme Court of New Jersey decided \*Hague v. Williams, supra.\* The principle that society is entitled to every person's evidence in order that the truth may be discovered may require a physician to testify in court about information obtained from a patient in the course of treatment. However, that principle has no application to disclosures made out of court. Hence, it [\*\*\*18] does not preclude a cause of action based on such disclosures.

\*In Massachusetts, the Legislature has demonstrated its recognition of a policy favoring confidentiality of medical facts by enacting G. L. c. 111, §§ 70 and 70E, to limit the availability of hospital records. Furthermore, G. L. c. 233, § 20B, creates an evidentiary privilege as to confidential communications between a psychotherapist and a patient. The fact that no such statutory privilege obtains with respect to physicians generally and their patients, \*Bratt v.\* International Business Machs. Corp., supra at 522 n.22, does not dissuade us from declaring [\*68] that in this Commonwealth all physicians owe their patients a duty, for violation of which the law provides a remedy, not to disclose without the patient's consent medical information about the patient, except to meet a serious danger to the patient or to others. See \*Horne v. Patton, supra at 709; Simonsen v. Swenson, supra at 227-229; \*Hague v. Williams, supra at 336; \*MacDonald v. Clinger, supra at 487; \*Berry v. Moench, 8 Utah 2d 191, 196-199 (1958); \*Hammonds v. Aetna Casualty & Sur. Co., supra at 797. [\*\*\*19] n4

n4 In <u>Bratt v. International Business Machs. Corp., supra</u> at 524, this court concluded that an employer may "have a substantial and valid interest in aspects of an employee's health that could affect the employee's ability effectively to perform job duties." We stated that "when medical information is necessary reasonably to serve such a substantial and valid interest of the employer, it is not an invasion of privacy, under [<u>G. L. c. 214</u>] § 1B, for a physician to disclose such information to the employer." *Id.* In that case, the physician was retained by the employer, and no physician-patient relationship existed. *Id.* at 510, 522 n.21. Furthermore, the court focused only on the privacy statute, and not on the nonstatutory duty of confidentiality we address today. The exception to the rule of confidentiality we announce

today is not so broad as to permit a physician to disclose to a patient's employer whatever information might bear on the "employee's ability effectively to perform job duties." <u>Id.</u> at 524. Disclosure is permitted only to meet a serious danger to the patient or to others.

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[\*\*120] It is true, as Devine argues, that no Massachusetts case before this one recognizes such a theory of liability. However, as we said in George v. Jordan Marsh Co., 359 Mass. 244, 249 (1971), a case in which we recognized for the first time the tort of infliction of emotional distress, "[t]hat is true only because the precise question has never been presented to this court for decision. That argument is therefore no more valid than would be an argument by the plaintiff that there is no record of any Massachusetts law denying recovery on such facts. No litigant is automatically denied relief solely because he presents a question on which there is no Massachusetts judicial precedent. It would indeed be unfortunate, and perhaps disastrous, if we were required to conclude that at some unknown point in the dim and distant past the law solidified in a manner and to an extent which makes it impossible now to answer a question which had not arisen and been answered [\*69] prior to that point. HN107The courts must, and do, have the continuing power and competence to answer novel questions of law arising under ever changing conditions of the society which the law is [\*\*\*21] intended to serve." In Smith v. Driscoll, 94 Wash. 441, 442 (1917), although the court found it unnecessary to determine "whether a cause of action lies in favor of a patient against a physician for wrongfully divulging confidential communications," the court "assumed" that "for so palpable a wrong, the law provides a remedy." We, too, believe that for so palpable a wrong, the law provides a remedy.

In <u>Hammonds v. Aetna Casualty & Sur. Co., supra at 802-803</u>, the court held that from HN11 the contractual relationship between a physician and a patient there arises a fiduciary obligation to hold in trust confidential information. In <u>MacDonald v. Clinger, supra at 486</u>, the court concluded that the physician-patient relationship "contemplates an additional duty springing from but extraneous to the contract and that the breach of such duty is actionable as a tort." This court previously has recognized that the physician-patient relationship possesses fiduciary (see <u>Warsofsky v. Sherman, 326 Mass. 290, 292</u> [1950]), as well as contractual (see <u>Sullivan v. O'Connor, 363 Mass. 579, 583</u> [1973]), aspects. We hold today that HN12 duty of confidentiality arises [\*\*\*22] from the physician-patient relationship and that a violation of that duty, resulting in damages, gives rise to a cause of action sounding in tort against the physician.

Reported Question 2. Nonstatutory invasion of privacy. On October 23, 1973, the Legislature approved St. 1973, c. 941, "An Act establishing the right of privacy and a remedy to enforce such right." The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. L. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing: HN13 The Act amended G. C. c. 214 by inserting § 1B, providing § 1B, p have a right against unreasonable, substantial or serious interference with his privacy. The superior court shall have jurisdiction in equity to enforce such right and in connection therewith to award damages." n5 As the parties recognize, the privacy statute does not apply here because [\*70] the facts alleged by Alberts occurred in 1972, before the statute's enactment. Therefore, Alberts asks us to recognize for the first time a common law cause of action for invasion of privacy. Before the Legislature established a statutory right of privacy, this court stated that "[w]e need not discuss to [\*\*121] what extent in Massachusetts violation of privacy will give rise to tort liability to individuals." Commonwealth v. Wiseman [\*\*\*23], 356 Mass. 251, 258 (1969). In a line of earlier cases, we explicitly refused to decide whether a common law right of privacy existed in this Commonwealth. See Frick v. Boyd, 350 Mass. 259, 263 (1966), and cases cited. We need not decide that question now. Even if there was a right of privacy at common law, that right would not permit recovery in this case beyond the recovery available for a physician's violation of the duty of confidentiality, recognized in our answer to reported question 1, and for the inducement of such a violation, recognized in our answer to question 3.

n5 General Laws c. 214, as appearing in St. 1973, c. 1114, $\S$ 62, contained no $\S$ 1B, but, t St. 1974, c. 193, $\S$ 1, the Legislature reenacted $\S$ 1B as it appeared in St. 1973, c. 941.

Reported Question 3. Effect of the religion clauses. Before discussing the religion clauses, we must consider whether, apart from them, a patient may hold liable one who induces a physician to violate the duty of confidentiality that the physician [\*\*\*24] owes the patient. We hold that HN14\* one who, with the state of mind we describe below, induces a physician wrongfully to disclose information about a patient, may be held liable to the patient for the damages that flow from that disclosure. The inducement need not be a threat, nor a promise of reward, but "may be a simple request or persuasion exerting only moral pressure."

Restatement (Second) Torts § 766 comment k (1979).

HN15 To establish liability the plaintiff must prove that: (1) the defendant knew or reasonably should have known of the existence of the physician-patient relationship; (2) the defendant intended to induce the physician to disclose information about the patient or the defendant reasonably should have anticipated that his actions would induce the physician to disclose such information; and (3) the defendant did not reasonably believe that the physician could disclose that information to the defendant without violating the duty of confidentiality that the physician [\*71] owed the patient. See Hammonds v. Aetna Casualty & Sur. Co., supra at 803; Restatement (Second) of Torts § 876(b) (1979) ("For harm resulting to a third person from the tortious conduct [\*\*\*25] of another, one is subject to liability if he knows . . . (b) that the other's conduct constitutes a breach of duty and gives substantial assistance or encouragement to the other so to conduct himself"); Restatement of Torts § 757(c) (1939) (before one is subject to liability for use or disclosure of a trade secret obtained from another one must have notice of the fact that disclosure of the trade secret by the other is a breach of duty) (see Curtiss-Wright Corp. v. Edel-Brown Tool & Die Co., 381 Mass. 1, 5-6 [1980]); Banks v. Everett Nat'l Bank, 305 Mass. 178, 182 (1940) ("one who participates in the breach of trust by a fiduciary is responsible for the damages resulting to the trust if he knew that the fiduciary was committing such a breach or if he had knowledge of such facts that he could not reasonably be held to have acted in good faith"); Restatement (Second) of Torts § 766 comment i (1979) (to be subject to liability for interference with a contractual relationship a person must have knowledge of the contract and that he is interfering with it).

The principle we announce is but an application of the general rule that HN16 a plaintiff may hold liable one who [\*\*\*26] intentionally induces another to commit any tortious act that results in damage to the plaintiff. See Nelson v. Nason, 343 Mass. 220, 222 (1961) (negligence); Halberstam v. Welch, 705 F.2d 472, 481-486, 487-489 (D.C. Cir. 1983) (burglary and murder); Cobb v. Indian Springs, Inc., 258 Ark. 9, 16-17 (1975) (negligence); Smith v. Thompson, 103 Idaho 909, 911-912 (Ct. App. 1982) (arson); Duke v. Feldman, 245 Md. 454, 457 (1966) (assault and battery); Rael v. Cadena, 93 N.M. 684, 684-685 (Ct. App. 1979) (battery); Russell v. Marlboro Books, 18 Misc. 2d 166, 179 (N.Y. Sup. Ct. 1959) (libel).

In this case, deposition testimony established that Carroll and Barclay knew of the physician-patient relationship between Devine and Alberts and that they [\*\*122] intended to induce Devine to disclose information about Alberts. To be entitled to summary judgment, therefore, apart from consideration of the [\*72] relationship between church and State, Carroll and Barclay had to demonstrate that there was no dispute of material fact that they reasonably believed that Devine could give them the information they sought without violating [\*\*\*27] his duty of confidentiality owed to Alberts. Carroll and Barclay did not do so.

We now reach the third reported question: "[W]hether the actions of the defendants Barclay and Carroll are within the ambit of the privileges and immunities granted by the First and Fourteenth Amendments of the United States Constitution." We read the reported question to include two questions. First, do the religion clauses preclude the imposition of liability on Carroll and Barclay? And, second, in connection with Alberts's proof of damages, may the court constitutionally inquire into the church's proceedings that resulted in Alberts's failure to gain reappointment as minister of the Old West Church?

We begin with the recognition that HN17\* the First Amendment prohibits civil courts from intervening in disputes concerning religious doctrine, discipline, faith, or internal organization. Jones v. Wolf, 443 U.S. 595, 602 (1979). Serbian E. Orthodox Diocese for the U.S. & Can. v. Milivojevich, 426 U.S. 696, 709 (1976). Presbyterian Church in the U.S. v. Mary Elizabeth Blue Hull Memorial Presbyterian Church, 393 U.S. 440, 449 (1969). Watson v. Jones, 80 U.S. (13 Wall.) 679, [\*\*\*28] 727 (1871). See United Kosher Butchers Ass'n v. Associated Synagogues of Greater Boston, Inc., 349 Mass. 595, 598 (1965); Reardon v. Lemoyne, 122 N.H. 1042, 1047 (1982). Carroll and Barclay claim that, as Alberts's clerical superiors, they had the duty to obtain information about Alberts's mental and emotional well-being, and that the Book of Discipline of the United Methodist Church privileged them to seek such information from Devine. They argue that the principle enunciated in the cases cited above precludes judicial inquiry into the merit of Alberts's claims against them and into the process by which the members of the church voted to retire Alberts. We disagree.

It is clear that \*\*\*\*\* the assessment of an individual's qualifications to be a minister, and the appointment and retirement of ministers, are ecclesiastical matters entitled to constitutional protection [\*73] against judicial or other State interference. \*\*Kedroff v. St. Nicholas\*\* Cathedral, 344 U.S. 94, 116 (1952). \*\*Gonzalez v. \*\*Roman Catholic Archbishop of Manila, 280 U.S. 1, 16-17 (1929). \*\*Kaufmann v. \*\*Sheehan, 707 F.2d 355, 358-359 (8th Cir. 1983).\*\* However, this case does not involve [\*\*\*29] the propriety of the United Methodist Church's refusal to reappoint Alberts as minister of the Old West Church. Nor does this case involve Alberts's qualifications to serve as a minister. A controversy concerning whether a church rule grants religious superiors the civil right to induce a psychiatrist to violate the duty of silence that he owes to a patient, who happens to be a minister, is not a dispute about religious faith or doctrine nor about church discipline or internal organization. Nor is a controversy concerning the causal connection between a psychiatrist's disclosure of confidential information and a minister's failure to gain reappointment such a dispute.

Even if the First Amendment precludes judicial inquiry as to whether a church rule provided that Carroll and Barclay had the right to seek medical information from Alberts's psychiatrist, so that the court must assume in Carroll's and Barclay's favor the existence of a church rule granting that right, it does not follow that the religion clauses preclude the imposition of liability on Carroll and Barclay. \*\*Although the freedom to believe "is absolute," the freedom to act "cannot be. Conduct remains subject to regulation [\*\*\*30] for the [\*\*123] protection of society. The freedom to act must have appropriate definition to preserve the enforcement of that protection." \*\*Attorney Gen. v. Bailey, 386 Mass. 367, 375 (1982), quoting \*\*Cantwell v. Connecticut, 310 U.S. 296, 303-304 (1940). See \*\*Braunfeld v. Brown, 366 U.S. 599, 603 (1961); \*\*Reynolds v. United States, 98 U.S. 145, 164 (1878).

motivated conduct does not violate the First Amendment if the State's interest in the law's enforcement outweighs the burden that the law imposes on the free exercise of religion. A determination of constitutionality requires a balancing of the competing interests. See Wisconsin v. Yoder, 406 U.S. 205, 215-229 (1972). Prince v. Massachusetts, 321 U.S. 158, 164-170 [\*74] (1944). Cantwell v. Connecticut, supra at 307. Catholic High School Ass'n of the Archdiocese of N.Y. v. Culvert, 753 F.2d 1161, 1169 (2d Cir. 1985). Obviously, the imposition of liability on Carroll and Barclay for inducing a violation of Devine's duty to Alberts

would inhibit such conduct. We must determine [\*\*\*31] whether such inhibition burdens the free exercise of religion by Carroll, Barclay, or the United Methodist Church, and if it does, we must then determine whether the Commonwealth possesses an interest sufficiently compelling to justify the burden. See <u>Wisconsin v. Yoder, supra. Sherbert v. Verner, 374 U.S. 398, 403-409 (1963). Catholic High School Ass'n of the Archdiocese of N.Y. v. Culvert, supra at 1171. Attorney Gen. v. Bailey, supra at 375.</u>

As we have observed, churches have a significant interest in assessing the qualifications of their ministers, and in appointing and retiring them. But, in view of the freedom that ecclesiastical authorities and church members have to determine who the church's ministers will be, and in view of the numerous sources of relevant information available to assist those making such determinations -- other than information available only from a minister's physician -- a rule that prevents interference with physician-patient relationships will have little impact on the free exercise of religion. On the other hand, as we have discussed earlier in this opinion, public policy strongly favors judicial recognition of a physician's [\*\*\*32] duty to honor the confidentiality of information gained through the physician-patient relationship. We conclude, therefore, that even if it be assumed, without inquiry, that the Book of Discipline or other rule of the United Methodist Church provides that Carroll and Barclay had a right, or even a duty, to seek medical information about Alberts from Devine, the First Amendment does not preclude the imposition of liability on those defendants. We also conclude that the First Amendment does not bar judicial inquiry into the church's proceedings culminating in Alberts's failure to gain reappointment.

Reported Question 4. Protective order. The final reported question asks: "[W]hether [the judge] properly invoked the First Amendment in entering the protective order for defendants [\*75] Barclay and Carroll." We answer that question "no." As we have stated, the First Amendment does not preclude civil courts from examining the proceedings that resulted in Alberts's failure to gain reappointment as minister of the Old West Church in order to determine whether that event resulted from wrongful conduct of the defendants. Accordingly, the First Amendment does not present an obstacle [\*\*\*33] to Alberts's right to discovery and trial evidence bearing on that issue. This litigation in no sense involves repetitious inquiry or continuing surveillance that would amount to the excessive entanglement between government and religion that the First Amendment prohibits. See Lynch v. Donnelly, 465 U.S. 668, 672-673 (1984); Lemon v. Kurtzman, 403 U.S. 602, 611-625 [\*\*124] (1971); Walz v. Tax Comm'n of the City of N.Y., 397 U.S. 664, 668-669 (1970); Surinach v. Pesquera de Busquets, 604 F.2d 73, 78 (1st Cir. 1979).

Conclusion. We hold today that, absent the patient's consent or a serious danger to the patient or to others, a physician owes to a patient a duty not to disclose information gained through the physician-patient relationship, and a violation of that duty gives rise to a cause of action sounding in tort. Therefore, we answer reported question number one "yes." No answer to reported question number two is required. Finally, we conclude that the religion clauses of the First Amendment do not preclude the imposition of liability on Carroll and Barclay nor bar the courts of this Commonwealth from inquiring into the church's proceedings [\*\*\*34] that resulted in Alberts's failure to gain reappointment as minister of Boston's Old West Church. Therefore, we answer reported questions number three and four "no," and, because Carroll and Barclay have not established by uncontroverted affidavits and other supporting materials that Alberts cannot prove his claims, we reverse the grant of summary judgment in favor of Carroll and Barclay and the judgments entered pursuant thereto, vacate the protective order entered below, and remand this case to the Superior Court for further proceedings not inconsistent with this opinion.

So ordered.

Source: My Sources > / . . . / > MA State Cases, Combined (i)

Terms: name(alberts and devine) and date(geq (1/01/85) and leq (12/31/85)) (Edit Search)

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# Site Leader Addendum

## **Section Twelve: Facilitating Improvement Teams**

This section of the Toolkit provides you with tools and resources for organizing your own project team to focus on improving the level of sexual history taking, chlamydia screening and treatment, partner management and prevention counseling provided to your teen patients. The agendas are designed to assist you to focus on the major topics contained within this Toolkit and to assist you in putting the Recommendations, educational materials and Toolkit information to use within your practice. The tips for meeting facilitation and quality improvement information are intended to be a refresher only. You may also want to share this information with colleagues and office support staff who may need this information.

We want to make implementation of the recommendations and educational materials as simple as possible for you by providing easy-to-use information. Which materials you use or how you use them is entirely up to your office to decide.

Here's what you'll find:

- Improvement teams
- Ground rules for improvement teams
- Suggested agenda highlights
- Refresher: Meeting facilitation skills.
- The continuous quality improvement process: Plan-Do-Check-Act.

## Improvement teams

In an effort to implement the "Recommendations for the Management and Prevention of Chlamydial Infections" among adolescents the use of a continuous quality improvement process is suggested. Our experience with the MassHealth Chlamydia pilot project suggests that this process will have an enhanced likelihood of success if:

- A small, core team is established, with a team leader or co-leaders and members who agree to meet on a regular schedule that they mutually determine
- Meetings are scheduled no less frequently than monthly
- Meeting expectations and decision-making methods are clearly stated
- The mechanism for sharing outcomes and promoting behavior change throughout the practice is clearly defined

In addition, the following basic steps are suggested

- Conduct baseline chart review of current patterns for sexual history taking, chlamydia screening and treatment as compared to the practices suggested by the Recommendations;
- If desired, receive training on the Recommendations and their relevance to your current performance related to screening and treatment of adolescents for chlamydia infection;
- Work with a quality improvement facilitator to plan a clinical and educational intervention designed to improve at least one area of care related to the evaluation and treatment of chlamydial infections in adolescents;
- Implement intervention(s) and track improvement through additional chart reviews.

## **Ground rules for Improvement teams**<sup>96</sup>

Finding the time for productive, efficient project team meetings can be difficult in a busy healthcare setting. Using ground rules at meetings is one way of trying to ensure that your committee meetings are useful to all people who attend. The purpose of ground rules is to determine how your group will work together to get its work done.

#### Getting started with committee ground rules

A process to develop ground rules is:

- Begin by telling folks that you want to set up some ground rules that everyone will follow as we go through our meeting. Put a blank sheet of newsprint on the wall with the heading "Ground Rules."
- Ask for any suggestions from the group. If no one says anything, start by putting one up yourself. That usually starts people off.
- Write any suggestions up on the newsprint. It's usually most effective to "check-in" with the whole group before you write up an idea. ("Sue suggested raising our hands if we have something to say. Is that O.K. with everyone?") Once you have gotten 5 or 6 good rules up, check to see if anyone else has other suggestions.

When you are finished, ask the group if they agree with these ground rules and are willing to follow them. Make sure you get folks to actually say "Yes" out loud. It makes a difference!

#### Making ground rules work

Ground rules are most effective if they are briefly revisited at the start of every committee meeting. This reminds participants of their agreement to work together according to a shared set of expectations and rules. It is the responsibility of the meeting facilitator or an assigned "sergeant at arms" to ensure ground rules are followed during meeting times.

#### Suggested ground rules

What follows is a list of suggested ground rules you may want to use to initiate your conversation about the ground rules for your project site team.

- 1) All participants will receive the meeting agenda and preparatory materials prior to the start of the meeting.
- 2) The agenda shall be followed as closely as possible.
- 3) Meetings shall start and end on time.
- 4) Listen to and respect the opinions of others.
- 5) Aim for balanced participation among group members.
- 6) One person at a time should speak, and no one should be interrupted.
- 7) Side conversations should be kept to a minimum.

<sup>&</sup>lt;sup>96</sup>Adapted from Chapter 10a-Section 3 of The Community Toolbox, "Developing Facilitation Skills" by Marya Axner and edited by Bill Berkowitz.

## Suggested agenda highlights

Several agendas have been developed to help you facilitate this simple process with your primary care quality improvement team.

#### Meeting one - convene project site team

- Welcome and introduce project team.
- Distribute handouts/Toolkit.
- Project orientation.
- Question and discussion.
- Next steps.
- Confirm date, time, location of next meeting.

## Meeting two – introduction to the recommendations for Chlamydia screening and treatment

- Welcome and introduce presenter(s).
- Training Program.
- Questions and discussion.
- Next steps.
- Confirm date, time, location of next meeting.

#### Meeting three - identify problem areas

- Welcome.
- Recap key discussion areas from training program.
- Review and discuss baseline chart review analysis.
- Questions and discussion.
- Next steps.
- Confirm date, time, location of next meeting.

#### Meeting four – identify problem areas

- Welcome.
- Recap outcomes of previous meeting.
- Report progress on action items from previous meeting.
- Define site improvement goals.
- Next steps.
- Confirm date, time, location of next meeting.

## Suggested agenda highlights

#### Meeting five – planning improvement intervention(s)

- Welcome.
- Recap outcomes of previous meeting.
- Report on action items from previous meeting.
- Toolkit orientation (review improvement areas and resources).
  - Confidentiality and the teen friendly office
  - Cultural issues that affect diagnosis and treatment
  - Sexual history taking
  - Providing prevention counseling
  - Chlamydia screening and treatment
  - Partner management
  - Information and referral resources
  - Patient education materials
  - Tools
  - Relevant laws
- Next steps.
- Confirm date, time, location of next meeting.

#### **Meeting six – planning improvement intervention(s)**

- Welcome.
- Recap outcomes of previous meeting.
- Report progress on action items from previous meeting.
- Select clinical improvement interventions to support improvement goals.
- Identify relevant Toolkit resources.
- Develop intervention plan inclusive of:
  - Timelines.
  - Accountability.
  - Resources to be utilized.
  - Communication.
  - Monitoring.
- Next steps.
- Confirm date, time, location of next meeting.

## Suggested agenda highlights

#### **Meeting seven – planning improvement intervention(s)**

- Welcome.
- Recap outcomes of previous meeting.
- Report progress on action items from previous meeting.
- Select educational improvement interventions to support improvement goals.
- Identify relevant Toolkit resources.
- Develop intervention plan inclusive of:
  - Timelines.
  - Accountability.
  - Resources to be utilized.
  - Communication.
  - Monitoring.
- Next steps.
- Confirm date, time, location of next meeting.

#### Meeting eight - midcourse technical assistance

- Welcome.
- Recap outcomes of previous meeting.
- Report progress on action items from previous meeting.
- Review midcourse chart review analysis.
- Field questions/key areas of concern for opinion leader to address.
- Educational program.
- Next steps.
- Confirm date, time, location of next meeting.

## **Refresher: Meeting facilitation skills**

Contributed by Marya Axner Edited by Bill Berkowitz



#### What are facilitation skills?

One of the most important sets of skills for leaders and members are facilitation skills. These are the "process" skills we use to guide and direct key parts of our organizing work with groups of people such as meetings, planning sessions and training of our members and leaders.

Whether it's a meeting (big or small) or a training session, someone has to shape and guide the process of working together so that you meet your goals and accomplish what you've set out to do. While a group of people might set the agenda and figure out the goals, one person needs to concentrate on how you are going to move through your agenda and meet those goals effectively. This is the person we call the "facilitator."

#### So, how is facilitating different from chairing a meeting?

Well, facilitation has three basic principles:

- A facilitator is a guide to help people move through a process together, not the seat of wisdom and knowledge. That means a facilitator isn't there to give opinions, but to draw out opinions and ideas of the group members.
- Facilitation focuses on HOW people participate in the process of learning or planning, not just on WHAT gets achieved.
- A facilitator is neutral and never takes sides.

The best meeting chairs see themselves as facilitators. While they have to get through an agenda and make sure that important issues are discussed, decisions made, and actions taken, good chairs don't feel that they have all of the answers or should talk all the time. The most important thing is what the participants in the meeting have to say. So, focus on how the meeting is structured and run to make sure that everyone can participate. This includes things like:

- Making sure everyone feels comfortable participating.
- Developing a structure that allows for everyone's ideas to be heard.
- Making members feel good about their contribution to the meeting.
- Making sure the group feels that the ideas and decisions are theirs, not just the leader's. Supporting everyone's ideas and not criticizing anyone for what they've said.

#### Why do you need facilitation skills?

If you want to do good planning, keep members involved, and create real leadership opportunities in your organization and skills in your members, you need facilitator skills. The more you know about how to shape and run a good learning and planning process, the more your members will feel empowered about their own ideas and participation, stay invested in your organization, take on responsibility and ownership, and the better your meetings will be.

#### Facilitating a meeting or planning session: What's it all about?

The three basic parts of facilitation are:

- The process of the meeting.
- Skills and tips for guiding the process.
- Dealing with disrupters: preventions and interventions.

#### The meeting process

As we've already said, the facilitator is responsible for providing a "safe" climate and working atmosphere for the meeting. But you're probably wondering, "What do I actually do DURING the meeting to guide the process along?" Here are the basic steps that can be your facilitator's guide:

#### 1. Start the meeting on time.

Few of us start our meetings on time. The result? Those who come on time feel cheated that they rushed to get there! Start no more than five minutes late, ten at the maximum, and thank everyone who came on time. When latecomers straggle in, don't stop your process to acknowledge them. Wait until after a break or another appropriate time to have them introduce themselves.

#### 2. Welcome everyone.

Make a point to welcome everyone who comes. Don't complain about the size of a group if the turnout is small! Nothing will turn the folks off who DID come out faster. Thank all of those who are there for coming and analyze the turnout attendance later. Go with who you have.

#### 3. Make introductions, especially if new participants are present.

There are lots of ways for people to introduce themselves to each other that are better than just going around the room. The kinds of introductions you do should depend on what kind of meeting you are having, the number of people, the overall goals of the meeting, and what kind of information it would be useful to know. Some key questions you can ask members to include in their introductions are:

- How did you first get involved with our organization? (if most people are already involved, but the participants don't know each other well)
- What do you want to know about our organization? (if the meeting is set to introduce your organization to another organization)
- What makes you most angry about this problem? (if the meeting is called to focus on a particular problem)

Sometimes, we combine introductions with something called an "ice breaker." Ice breakers can:

- Break down feelings of unfamiliarity and shyness.
- Help people shift roles from their "work" selves to their "more human" selves.
- Build a sense of being part of a team.
- Create networking opportunities.
- Help share participants' skills and experiences.

Some ways to do introductions and icebreakers are:

- In pairs, have people turn to the person next to them and share their name, organization and three other facts about themselves that others might not know. Then, have each pair introduce EACH OTHER to the group. This helps to get strangers acquainted and for people to feel safe they already know at least one other person, and didn't have to share information directly in front of a big group at the beginning of the meeting.
- Form small groups and have each of them work on a puzzle. Have them introduce themselves to their group before they get to work. This helps to build a sense of team work.
- In a large group, have everyone write down two true statements about themselves and one false one. Then, every person reads their statements and the whole group has to guess which one is false. This helps folks get acquainted and relaxed.
- Give each participant a survey and have the participants interview each other to find the answers. Make the questions about skills, experience, opinions on the issue you'll be working on, etc. When everyone is finished, have folks share the answers they got.

When doing introductions and icebreakers, it's important to remember:

- Every participant needs to take part in the activity. The only exception may be latecomers who arrive after the introductions are completed. At the first possible moment, ask the latecomers to say their name and any other information you feel they need to share in order for everyone to feel comfortable and equal.
- Be sensitive to the culture, age, gender and literacy levels of participants and any other factors when deciding how to do introductions. For example, an activity that requires physical contact or reading a lengthy instruction sheet may be inappropriate for your group. Also, keep in mind what you want to accomplish with the activity. Don't make a decision to do something only because it seems like fun.
- It is important to make everyone feel welcome and listened to at the beginning of the meeting. Otherwise, participants may feel uncomfortable and unappreciated and won't participate well later on. Also, if you don't get some basic information about who is there, you may miss some golden opportunities. For example, the editor of the regional newspaper may be in the room, but if you don't know, you'll miss the opportunity for a potential interview or special coverage.
- And don't forget to introduce yourself. You want to make sure that you establish some credibility to be facilitating the meeting and that folks know a bit about you. Credibility doesn't mean you have a college degree or 15 years of facilitation experience. It just means that you share some of your background so folks know why you are doing the facilitation and what has led you to be speaking up.

#### 4. Review the agenda, objectives and ground rules for the meeting.

Go over what's going to happen in the meeting. Check with the group to make sure they agree with and like the agenda. You never know if someone will want to comment and suggest something a little different. This builds a sense of ownership of the meeting and lets people know early on that you're there to facilitate THEIR process and THEIR meeting, not your own agenda. The same is true for the outcomes of the meeting. You'll want to go over these with folks as well to get their input and check that these are the desired outcomes they're looking for. This is also where the ground rules that we covered earlier come in.

#### 5. Encourage participation.

This is one of your main jobs as a facilitator. It's up to you to get those who need to listen to listen and those who ought to speak to do so. Encourage people to share their experiences and ideas and urge those with relevant background information share it at appropriate times.

#### 6. Stick to the agenda.

Groups have a tendency to wander far from the original agenda, sometimes without knowing it. When you hear the discussion wandering off, bring it to the group's attention. You can say, "That's an interesting issue, but perhaps we should get back to the original discussion."

#### 7. Avoid detailed decision-making.

Sometimes, it's easier for groups to discuss the color of napkins than the real issues they are facing. Help the group not to get immersed in details. Suggest instead, "Perhaps the committee could resolve the matter. Do you really want to be involved in that level of detail?"

#### 8. Seek commitments.

Getting commitments for future involvement is often a meeting goal. You want leaders to commit to certain tasks, people to volunteer to help on a campaign, or organizations to support your group. Make sure adequate time is allocated for seeking commitment. For small meetings, write people's names down on newsprint next to the tasks they agreed to undertake. One important rule of thumb is that no one should leave a meeting without something to do. Don't ever close a meeting by saying, "We'll get back to you to confirm how you might like to get involved." Seize the moment! Sign them up!

#### 9. Bring closure to each item.

Many groups will discuss things ten times longer than they need to unless a facilitator helps them to recognize they're basically in agreement. Summarize a consensus position, or ask someone in the group to summarize the points of agreement, and then move forward. If one or two people disagree, state the situation as clearly as you can: "Tom and Levonia seem to have other feelings on this matter, but everyone else seems to go in this direction. Perhaps we can decide to go in the direction that most of the group wants, and maybe Tom and Levonia can get back to us on other ways to accommodate their concerns." You may even suggest taking a break so Tom and Levonia can caucus to come up with some options.

Some groups feel strongly about reaching consensus on issues before moving ahead. If your group is one of them, be sure to read a good manual or book on consensus decision making. Many groups, however, find that voting is a fine way to make decisions. A good rule of thumb is that a vote must pass by a two-thirds majority for it to be a valid decision. For most groups to work well, they should seek consensus where possible, but take votes when needed in order to move the process forward.

#### 10. Respect everyone's rights.

The facilitator protects the shy and quiet folks in a meeting and encourages them to speak out. There is also the important job of keeping domineering people from monopolizing the meeting or ridiculing the ideas of others.

Sometimes, people dominate a discussion because they are really passionate about an issue and have lots of things to say. One way to channel their interest is to suggest that they consider serving on a committee or task force on that issue. Other people, however, talk to hear themselves talk. If someone like that shows up at your meeting, look further ahead in this chapter for some tips on dealing with "disrupters."

#### 11. Be flexible.

Sometimes issues will arise in the meeting that are so important, they will take much more time than you thought. Sometimes, nobody will have thought of them at all. You may run over time or have to alter your agenda to discuss them. Be sure to check with the group about whether this is O.K. before going ahead with the revised agenda. If necessary, ask for a five-minute break to confer with key leaders or participants on how to handle the issue and how to restructure the agenda. Be prepared to recommend an alternate agenda, dropping some items if necessary.

#### 12. Summarize the meeting results and needed follow-ups.

Before ending the meeting, summarize the key decisions that were made and what else happened. Be sure also to summarize the follow-up actions that were agreed to and need to take place. Remind folks how much good work was done and how effective the meeting hopefully was. Refer to the objectives or outcomes to show how much you accomplished.

#### 13. Thank the participants.

Take a minute to thank people who prepared things for the meeting, set up the room, brought refreshments, or did any work towards making the meeting happen. Thank all of the participants for their input and energy and for making the meeting a success.

#### 14. Close the meeting.

People appreciate nothing more than a meeting that ends on time! It's usually a good idea to have some "closure" in a meeting, especially if it was long, if there were any sticky situations that caused tension, or if folks worked especially hard to come to decisions or make plans. A nice way to close a meeting is to go around the room and have people say one word that describes how they are feeling now that all of this work has been done. You'll usually get answers from "exhausted" to "energized!" If it's been a good meeting, even the "exhausted" ones will stick around before leaving.

## Facilitator skills and tips

Here are a few more points to remember that will help to maximize your role as a facilitator:

#### 1. Don't memorize a script.

Even with a well-prepared agenda and key points you must make, you need to be flexible and natural. If people sense that you are reading memorized lines, they will feel like they are being talked down to, and won't respond freely.

#### 2. Watch the group's body language.

Are people shifting in their seats? Are they bored? Tired? Looking confused? If folks seem restless or in a haze, you may need to take a break, or speed up or slow down the pace of the meeting. And if you see confused looks, you may need to stop and check in with the group, to make sure that everyone knows where you are on the agenda and that the group is with you.

#### 3. Always check back with the group.

Be careful about deciding where the meeting should go. Check back after each major part of the process to see if there are questions and make sure that everyone understands and agrees with decisions that were made.

#### 4. Summarize and pause.

When you finish a point or a part of the meeting process, sum up what was done and decided, and pause for questions and comments before moving on. Learn to "feel out" how long to pause -- too short, and people don't really have time to ask questions; too long, and folks will start to get uncomfortable from the silence.

#### 5. Be aware of your own behavior.

Take a break to calm down if you feel nervous or are losing control. Watch that you're not repeating yourself, saying "ah" between each word, or speaking too fast. Watch your voice and physical manner. (Are you standing too close to folks so they feel intimidated, making eye contact so people feel engaged?) How you act makes an impact on how participants feel.

#### 6. Occupy your hands.

Hold onto a marker, chalk or the back of a chair. Don't play with the change in your pocket!

#### 7. Watch your speech.

Be careful that your language or behavior does not offend or alienate anyone in the group.

#### 8. Use body language of your own.

Using body language to control the dynamics in the room can be a great tool. Moving up close to a shy, quiet participant and asking them to speak may make them feel more willing, because they can look at you instead of at the big group and feel less intimidated. Also, walking around engages people in the process. Don't just stand in front of the room for the entire meeting.

#### 9. Don't talk to the newsprint, blackboard or walls - they can't talk back!

Always wait until you have stopped writing and are facing the group to talk.

## **Dealing with disrupters: Preventions and interventions**

Along with these tips on facilitation, there are some things you can do both to prevent disruption before it occurs and also to stop it when it's happening in the meeting. The most common kinds of disrupters are people who try to dominate, keep going off the agenda, have side conversations with the person sitting next to them, or folks who think they are right and ridicule and attack other's ideas.

## Try using these "Preventions" when you set up your meeting to try to minimize disruption:

#### 1. Get agreement on the agenda, ground rules and outcomes.

In other words, agree on the process. These process agreements create a sense of shared accountability and ownership of the meeting, joint responsibility for how the meeting is run, and group investment in whether the outcomes and goals are achieved.

#### 2. Listen carefully.

Don't just pretend to listen to what someone in the meeting is saying. People can tell. Listen closely to understand a point someone is making. And check back if you are summarizing, always asking the person if you understood his or her idea correctly.

#### 3. Show respect for experience.

We can't say it enough. Encourage folks to share strategies, stories from the field and lessons they've learned. Value the experience and wisdom in the room.

#### 4. Find out the group's expectations.

Make sure that you uncover at the start the reason that participants think they are meeting. When you find out, be clear about what will and won't be covered in this meeting. Make plans for how to cover issues that won't be dealt with. Write them down on newsprint and agree to deal with them at the end of the meeting, or have the group agree on a follow-up meeting to cover unfinished issues.

There are lots of ways to find out what the group's expectations of the meeting are. Try asking everyone to finish this sentence: "I want to leave here today knowing...." You don't want people sitting through the meeting feeling angry that they're in the wrong place and no one bothered to ask them what they wanted to achieve here. These folks may act out their frustration during the meeting and become your biggest disrupters.

#### 5. Stay in your facilitator role.

You cannot be an effective facilitator and a participant at the same time. When you cross the line, you risk alienating participants, causing resentment and losing control of the meeting. Offer strategies, resources and ideas for the group to work with, but NOT opinions.

#### 6. Don't be defensive.

If you are attacked or criticized, take a "mental step" backwards before responding. Once you become defensive, you risk losing the group's respect and trust, and might cause folks to feel they can't be honest with you.

#### 7. "Buy-in" power players.

Be sure to identify who these people are. These folks can turn your meeting into a night-mare if they don't feel that their influence and role are acknowledged and respected. If possible, give them acknowledgment up front at the start of the meeting. Try giving them roles to play during the meeting such as a "sounding board" for you at breaks, to check in with about how the meeting is going.

#### Try using these "Interventions" when disruption is happening during the meeting:

#### 1. Have the group decide.

If someone is dominating the meeting, refuses to stick to the agenda, keeps bringing up the same point again and again, or challenges how you are handling the meeting: First try to remind them about the agreed-on agenda. If that doesn't work, throw it back to the group members and ask them how they feel about that person's participation. Let the group support you.

#### 2. Use the agenda and ground rules.

If someone keeps going off the agenda, has side conversations through the whole meeting, verbally attacks others: Go back to that agenda and those ground rules and remind folks of the agreements made at the beginning of the meeting.

#### 3. Be honest: Say what's going on.

If someone is trying to intimidate you, if you feel upset or undermined, if you need to pull the group behind you. It is better to say what's going on than try to cover it up. Everyone will be aware of the dynamic in the room. The group will get behind you if you are honest and up-front about the situation.

#### 4. Use humor.

If there is a lot of tension in the room, if you have people at the meeting who didn't want to be there, if folks are scared/shy about participating, if you are an outsider: Try a humorous comment or a joke. If it's self-deprecating, so much the better. Humor almost always lightens the mood. It's one of the best tension-relievers we have.

#### 5. Accept or legitimize the point or deal.

If there is someone who keeps expressing doubts about the group's ability to accomplish anything, is bitter and puts down others' suggestions, keeps bringing up the same point over and over, seems to have power issues, try one or more of these approaches: Show that you understand his or her issue by making it clear that you hear how important it is to the person. Legitimize the issue by saying, "It's a very important point and one I'm sure we all feel is critical." Make a bargain to deal with their issue for a short period of time. ("O.K., let's deal with your issue for 5 minutes and then we ought to move on.") If that doesn't work, agree to defer the issue to the end of the meeting, or set up a committee to explore it further.

#### 6. Use body language.

If side conversations keep occurring, if quiet people need to participate, if attention needs to be re-focused: Use body language. Move closer to conversers, or to the quiet ones. Make eye contact with them to get their attention and convey your intent.

#### 7. Take a break.

If less confrontational tactics haven't worked, someone keeps verbally attacking others, shuffling papers, cutting others off and in case you've tried all of the above suggestions and nothing has worked, it's time to take a break, invite the disruptive person outside the room and politely but firmly state your feelings about how disruptive their behavior is to the group. Make it clear that the disruption needs to end. But also try to find out what's going on, and see if there are other ways to address that person's concerns.

#### 8. Confront in the room.

If all else has failed, if you're sure it won't create backlash, if the group will support you, and if you've tried everything else: Confront the disruptive person politely but very firmly in the room. Tell the person very explicitly that the disruption needs to stop now. Use body language to encourage other group members to support you. This is absolutely the last resort when action must be taken and no alternatives remain!

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#### Resources

Auvine, B., Dinsmore, B., Extrom, M., Poole, S., Shanklin, M. (1978).

<u>A manual for group facilitators</u>. Madison, WI: The Center for Conflict Resolution.

Bobo, K., Kendall, J., Max, S., (1991). <u>A manual for activists in the 1990s</u>. Cabin John, MD: Seven Locks Press.

Nelson-Jones, R. (1992). <u>Group leadership: A training approach</u>. Pacific Grove, CA: Brooks/Cole.

Schwarz, R.M. (1994). The skilled facilitator: Practical wisdom for developing effective groups. San Francisco, CA: Jossey-Bass.

# The continuous quality improvement process: Plan, Do, Check, Act

#### 1. PLAN the change

- Precisely what change is to be made?
- How do you know the planned change is appropriate? Have other alternatives been explored? If no other alternatives have been explored, you may first want to work through the strategy.
- What sequence of major steps is needed for this change? What are the major substeps of each step? Map out the new process on a flowchart.
- Who will be directly involved in carrying out each step and substep? Who will need to be consulted?
- Whom will the change affect? Who will need to change the way they do their jobs? How will they need to change the way they do their jobs? How will they be trained? How will you get qualified trainers? How will the effects of the training be checked?

Do not surprise people with change. Get information to everybody before they hear rumors. Seek input from people who will be affected by the change. Explain the change and explain how it will affect them and how they will be kept informed. Ask then what they need to know to be comfortable with the change. Incorporate suggestions from them into the plan, if reasonable.

- What will you do about unexpected problems? Who will have the authority to take action?
- Taking all these factors into account, what can be done to increase the likelihood of success?
- How will you monitor and check the progress of the change? The effectiveness of the change? How will you measure the benefits of the change? What are the key points to monitor to determine if the change is proceeding as expected?
- How will you collect, review and act on this information?

#### 2. DO the change

• It is often best to carry out a small-scale study of the change before making it widespread. Train those whose jobs will change. Personally supervise execution of the change.

### 3. CHECK the change

• Monitor the progress and effectiveness of the change according to your plan. Gather data from key points. Check for side effects and backsliding.

### 4. Refine and standardize the change

- What did the information you collected tell you about the effectiveness of the change?
- What can be done to error proof the process?
- How can the change be refined? Do another Plan-Do-Check-Act cycle if refinements are substantial. Standardize the new procedures. Transfer responsibility for ongoing monitoring and improvement to everyday operators and supervisors.
- What do you need to complete the documentation of the change?
- What lessons learned here about the new procedure and implementing change apply elsewhere? How can these lessons be communicated?

### 5. ACT on the change

• When you have refined your change, it is then time to put it into action at your practice.

Congratulations and good luck!

Adapted from: The Team Handbook by Peter R. Scholtes.

# Action plan worksheet – Plan-Do-Check-Act Cycle

An "Action Plan" is a prioritized checklist of what must be done to accomplish the state goal.	:d
Team:	
Goal:	

Who Assigned	Result	Date Completed
	Who Assigned	Who Assigned Result

# Section Thirteen: Evaluation of Your Quality Improvement Initiative

This section of the chlamydia Toolkit is designed to serve as a resource for you to store your assessment and evaluation data for your chlamydia improvement initiative. Many healthcare organizations get caught in the trap of conducting and never using needs assessments and other data. Storing your data in one space, along with your chlamydia improvement resources, may help to guarantee that information about your improvement efforts are easily accessible to you and other members of your improvement team.

# Chlamydia chart abstraction tool

1. Have you already entered the demographic information for this patient
☐ 1. Yes ☐ 2. No
[IF THE ANSWER IS 1, THEN SKIP TO QUESTION 8]
2. Enter site name:
□ 1 □ 2 □ 3
3. Enter date of review:
4. Enter name of reviewer:
5. Enter patient's primary care provider:
6. PCP specialty:
<ul> <li>1. Internist</li> <li>2. Pediatrician</li> <li>3. Family practice</li> <li>4. OB/Gyn</li> <li>5. Other</li> </ul>
[IF THE ANSWER IS NOT 5, THEN SKIP TO QUESTION 8

7. If other, then what?
8. Enter patient's project I.D. number:
[IF THE ANSWER TO QUESTION 1 IS 1, THEN SKIP TO QUESTION 19]
9. Enter patient's date of birth:
10. Patient's gender:
□ 1. Male □ 2. Female
11. Patient's primary spoken language:
<ul> <li>□ 1. English</li> <li>□ 2. Cambodian</li> <li>□ 3. Spanish</li> <li>□ 4. Portuguese</li> <li>□ 5. Haitian Creole</li> <li>□ 6. Chinese</li> <li>□ 7. Vietnamese</li> <li>□ 8. French</li> <li>□ 9. Other</li> <li>□ 0. Not noted</li> </ul>
[IF THE ANSWER IS NOT 9, THEN SKIP TO QUESTION 13]
12. If other, please specify:

13.	Were interpreter services needed?
	□ 1. Yes
	□ 2. No
	□ 3. Unknown
	[IF THE ANSWER IS 2, THEN SKIP TO QUESTION 16]
14.	Were interpreter services available for the visit?
	□ 1. Yes
	□ 2. No
	□ 3. Unknown
	[IF THE ANSWER IS 2, THEN SKIP TO QUESTION 16]
15.	Was the interpreter:
	☐ 1. A trained interpreter
	☐ 2. Non-medical staff
	☐ 3. A family member or partner
	□ 4. Unknown
16.	Patient's race/ethnicity:
	☐ 1. American Indian or Alaskan Native
	<ul><li>2. Asian</li><li>3. Black or African American</li></ul>
	☐ 4. Hispanic or Latino
	☐ 5. Native Hawaiian or Other Pacific Islander
	☐ 6. White ☐ 7. Other
	□ 8. Not noted
	[IF THE ANSWER IS NOT 7, THEN SKIP TO QUESTION 18]
17.	If other, please specify:
18.	Was confidentiality discussed?
	☐ 1. Yes - before the study period
	☐ 2. Yes - during the study period
	□ 3. No documentation

19.	Enter date of visit:
20.	Type of visit:  ☐ 1. Sick ☐ 2. Urogenital symptoms ☐ 3. Well visit ☐ 4. Other
	[IF THE ANSWER IS NOT 4, THEN SKIP TO QUESTION 22]
21.	If other, list reason for visit:
22.	Was a sexual history taken?  ☐ 1. Yes ☐ 2. No ☐ 3. Patient declined ☐ 4. No documentation
23.	Is the patient currently sexually active?  ☐ 1. Yes ☐ 2. No ☐ 3. Patient declined to respond ☐ 4. No documentation
24.	Has the patient ever been sexually active?  ☐ 1. Yes ☐ 2. No ☐ 3. Patient declined to respond ☐ 4. No documentation

25.	Was the patient screened for chlamydia?				
	□ 1. Yes				
	<ul><li>2. No</li><li>3. Patient declined</li></ul>				
	[IF THE ANSWER IS NOT 1, THEN SKIP TO QUESTION 43]				
26.	How was the patient screened?				
	<ul><li>1. Endocervical</li><li>2. Urethra</li></ul>				
	☐ 3. Urine				
	☐ 4. No documentation				
27.	Type of test:				
	1. NAAT				
	☐ 2. DNA probe ☐ 3. EIA				
	□ 4. DFA				
28.	Was the patient notified of the screening results?				
	□ 1. Yes □ 2. No				
	☐ 3. No documentation				
	[IF THE ANSWER IS NOT 1, THEN SKIP TO QUESTION 30]				
29.	How was the patient notified?				
	1. Phone				
	☐ 2. Letter ☐ 3. Beeper				
	☐ 4. On site / In person				
30.	Screening result:				
	☐ 1. Positive				
	<ul><li>2. Negative</li><li>3. No documentation</li></ul>				
	[IF THE ANSWER IS NOT 1, THEN SKIP TO QUESTION 43]				

31.	Was the patient treated?
	☐ 1 Yes ☐ 2 No ☐ 3 No documentation
	[IF THE ANSWER IS NOT 1, THEN SKIP TO QUESTION 35]
32.	How was the patient treated?
	<ul> <li>On site medication provided</li> <li>On site prescription provided</li> <li>Prescription by phone</li> </ul>
33.	What medication was prescribed?
	☐ 1 Azithromycin ☐ 2 Doxycycline ☐ 3 Other
	[IF THE ANSWER IS NOT 3, THEN SKIP TO QUESTION 35]
34.	If other, please specify:
35.	Was partner management discussed?
	□ 1 Yes □ 2 No
	☐ 3 Undocumented
	[IF THE ANSWER IS NOT 1, THEN SKIP TO QUESTION 43]
36.	Which action was agreed on?
	<ul> <li>□ 1 Patient will notify partner(s)</li> <li>□ 2 Provider will notify partner(s)</li> <li>□ 3 DPH will interview patient</li> <li>□ 4 Another action was taken</li> <li>□ 5 No action was agreed upon</li> <li>□ 6 Patient declined to have partner(s) informed</li> <li>□ 7 No documentation of action</li> </ul>
	[IF THE ANSWER IS NOT 4, THEN SKIP TO QUESTION 38]

37.	Please specify action taken:
38.	Please specify number of partners:
39.	Did partner(s) receive treatment?  1 Yes 2 No 3 Partner declined 4 No documentation  [IF THE ANSWER IS NOT 1, THEN SKIP TO QUESTION 43]
40.	How many partners had treatment?
41.	By whom did partner(s) receive treatment?  1 Partner's doctor 2 Patient's doctor 3 Family planning clinic 4 STD clinic 5 Other 6 No documentation  [IF THE ANSWER IS NOT 5, THEN SKIP TO QUESTION 43]
42.	If other, please specify:
43.	Thank you for participating in this survey.  □ 1 End of survey

### **Baseline chart review analysis**

# Pilot site quality improvement plan

# Midcourse chart review analysis

# Post-implementation chart review analysis